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THE CONCEPT OF CONFIDENCE OF OLDER PEOPLE LIVING WITH FRAILITY AND IMPLICATIONS FOR PRACTICE

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**UNIVERSITY OF
PLYMOUTH**

**THE CONCEPT OF CONFIDENCE OF OLDER PEOPLE LIVING
WITH FRAILTY AND IMPLICATIONS FOR PRACTICE**

by

FRAZER WILLIAM UNDERWOOD

10426454

A thesis submitted to the University of Plymouth
in fulfilment for the degree of

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Author's Declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.

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ABSTRACT

Frazer William UNDERWOOD

THE CONCEPT OF CONFIDENCE OF OLDER PEOPLE LIVING WITH FRAILTY AND IMPLICATIONS FOR PRACTICE

Background

Our human world is aging. The prevalence of older people living with syndromes of frailty is growing too. Frailty syndromes, such as falls, immobility, delirium, incontinence and susceptibility to medication side effects, are leading causes of acute hospitalisation of older people. Confidence is recognised to impact on individuals' physical health and mental well-being, despite it not being clearly expressed in the literature. Health and social care policy and practice now focus on frailty interventions to reduce long-term demands of this growing population. Understanding the relationship of the concept of confidence and its associated impact on the physical health and mental well-being of older people living with frailty is important. It is fundamental that opportunities are identified for interventional practice-based developments that address confidence-related issues.

Aim

To explore and develop a concept of 'confidence' in the context of older people living with frailty and to consider implications for practice.

Method

The Knowledge-to-Action Framework's knowledge creation funnel informed a four-stage interpretivist study design to explore and develop the concept of confidence. This sequential approach to knowledge growth included: qualitative systematic review meta-aggregation of the literature; primary concept construction; an interpretive phenomenological enquiry; and method triangulation to inform a final conceptual outcome.

Findings

Method triangulation identified convergence across the three studies to present a final concept of confidence from the perspectives of older people living with frailty. Four interdependent paradigms form this construct of confidence: social connectedness, fear, independence and control. This new concept connects the contemporary frailty care through the biopsychosocial and environmental cornerstones of Comprehensive Geriatric Assessment commonly adopted to manage frailty syndromes. It enables clearer understanding and opportunity for intervention along the continuums of health and frailty and of resilience and vulnerability.

Conclusion

Confidence is a word that can often be dismissed or misused. This research raises its status as a credible force in the lives of older people. The newly defined concept of confidence in older people living with frailty compellingly associates this with frailty models exposing assets as it does deficits. The new concept of confidence now needs empirical referents developing to measure and quantify impact across new interventional opportunities in practice.

Table of Contents

Acknowledgements.....	5
Author's Declaration.....	7
Research outputs.....	8
ABSTRACT.....	10
Table of Contents.....	13
List of Figures	20
List of Tables.....	23
CHAPTER 1:.....	25
EXPLORING THE NOTION OF CONFIDENCE: INTRODUCTION	25
My epistemic position	26
A brief synopsis of the problem	28
Purpose and significance of the study	31
The aim and objectives of the research study	32
Study design and theoretical framework.....	33
Overview of the thesis	37
CHAPTER 2:.....	40
A HISTORICAL PERSPECTIVE OF FRAILTY: THE LAST 25 YEARS	40
Early model developments	40
In search of consensus.....	44
Later model developments and concepts of frailty.....	46
Turning full circle	49
CHAPTER 3:.....	53
THE MEANING OF CONFIDENCE FOR OLDER PEOPLE LIVING WITH FRAILTY: A QUALITATIVE SYSTEMATIC REVIEW.....	53
Introduction.....	54
Executive summary:	55

Background	59
Review objective and question	65
Search strategy	67
Results	70
Discussion	84
Limitation of the review	85
Conclusions	86
Recommendations.....	86
CHAPTER 4:.....	90
CONFIDENCE RELATED TO OLDER PEOPLE LIVING WITH FRAILITY: A CONCEPT ANALYSIS	90
Introduction.....	91
Abstract	92
Introduction.....	93
Background	95
Two confidence connected constructs that conflict with conceptual development.....	96
Design	98
Method	98
Results	99
Discussion	109
Conclusion.....	112

Implications.....	112
CHAPTER 5:.....	115
UNDERSTANDING THE CONCEPT OF CONFIDENCE USING PHENOMENOLOGICAL ENQUIRY: STUDY DESIGN.....	115
Introduction.....	115
Interpretive phenomenology and its human science epistemology.....	117
Methodological structure for human science research	121
Discovering the lived experience of confidence: An interpretive phenomenology study protocol.....	128
Objectives.....	128
Sampling and sample size.....	129
Participants and participant selection	130
Consent.....	132
Data collection method.....	132
Data analysis.....	134
Ethical considerations	135
Appraising trustworthiness.....	138
Summary	140
CHAPTER 6:.....	141
THE LIVED EXPERIENCE OF CONFIDENCE: FINDINGS FROM THE PHENOMENOLOGICAL ENQUIRY.....	141
Introduction.....	141
Study and participants characteristics	142
Staged approach to the analysis of interviews.....	146

Interview findings.....	158
Essential theme analysis and development.....	181
Essential theme analysis and development.....	185
Essential theme one: The dimension of social connections	187
Essential theme two: The dimension of fear.....	192
Essential theme three: The dimension of independence.....	197
Essential theme four: The dimension of control	201
Others' views on the essential themes: the four dimensions	207
Summary	216
CHAPTER 7:.....	217
METHOD TRINGULATION: FORMULATING THE FINAL CONCEPT	217
Introduction.....	217
A method to reconstruct the final concept	218
Method triangulation: the evidence base.....	219
Method triangulation: application in practice.....	223
Judging the weight of evidence	223
Triangulation of the three dimensions of confidence: physical, social and psychological.....	225
The unique dimension of control	231
The impact of methodological triangulation on the final concept analysis of confidence.....	233
Summary	242

CHAPTER 8:.....	243
THE PARADIGMS OF CONFIDENCE: CONTRIBUTION TO KNOWLEDGE	243
Introduction.....	243
The development of a concept of confidence	244
Original knowledge discovery	246
The paradigm of social connections	248
The paradigm of fear	252
The paradigm of independence	258
The paradigm of control.....	261
Pragmatic application	272
Health and social care policy connections.....	272
Implications for practice	277
Older people's feedback.....	277
Knowledge to action: action cycle	278
Implications for research.....	280
Confidence measurement	280
Interventional study development.....	282
Theory development.....	283
Implications for education	285
Researcher-led dissemination of findings.....	285
Storytelling.....	286
Study appraisal and evaluation of trustworthiness.....	287

Appraisal of the phenomenological enquiry.....	287
Trustworthiness of the whole qualitative study	289
Study strengths and limitations.....	294
Reflecting back: strengths	295
Reflecting back: limitations.....	298
Summary	300
CHAPTER 9.....	302
THE CONCEPT OF CONFIDENCE OF OLDER PEOPLE LIVING WITH FRAILITY: THE FINAL SYNOPSIS	302
Answering the research question	303
Originality of this thesis.....	309
The importance of confidence and the impact of this concept.....	310
The importance of confidence for older people and for their carers	310
The impact of this new concept for older people and their carers	311
The importance of confidence for practice, service providers and wider society	312
Importance of this new concept for practice, service providers and wider society	313
My personal conclusions	314
Summary	317
APPENDICES.....	318
Appendix 1: Appendices from Chapter 3	319
Appendix 2: Appendices from Chapter 4	339

Appendix 3: Detailed phenomenological analysis of six older participants interviews.....	377
Appendix 4: Health Research Authority Ethics Approval Letter	415
Appendix 5: University of Plymouth Ethics Approval Letter	420
Appendix 6: Final correspondence approving the non-substantial protocol amendments.....	421
Appendix 7: COREQ Checklist (COnsolidated criteria for REporting Qualitative studies)	424
Appendix 8: Illustrations of the four paradigms of confidence.....	426
REFERENCES	431

List of Figures

Figure 1: The Knowledge Funnel, image adapted from Graham et al. (2006). .	34
Figure 2: The four stage interpretivist study design.	35
Figure 3: Representation of the scales illustrating the dynamic model of frailty from the Rockwood et al. (1994) paper.....	41
Figure 4: Venn diagram illustration the interlocking physical, psychological and social dimensions of frailty.	48
Figure 5: Illustration of the four-stage study design highlighting the study's first stage, the systematic review.....	54
Figure 6: Flow chart of the comprehensive search and study selection process.	71
Figure 7: Illustration of the four-stage study design highlighting the study's second stage, the primary concept analysis.	91
Figure 8: High-level illustration of the concept of confidence in older people living with frailty.....	101
Figure 9: The concept of confidence - illustration of Mrs. P. (Model case).....	106
Figure 10: Illustration of the four-stage study design highlighting the study's phenomenological enquiry stage.	115
Figure 11: The sequential interview strategy for the phenomenological enquiry.	134

Figure 12: Illustration of the four essential themes and key words that emerged from the seventeen older peoples' interviews.	187
Figure 13: Illustration of the dimension of social connections and key words that emerged from the seventeen older peoples' interviews.	188
Figure 14: Illustration of the dimension of fear and key words that emerged from the seventeen older peoples' interviews.	193
Figure 15: Illustration of the dimension of independence and key words that emerged from the seventeen older peoples' interviews.	198
Figure 16: Illustration of the dimension of control and key words that emerged from the seventeen older peoples' interviews.	202
Figure 17: Illustration of the four stage study design highlighting the study's final findings review stage.	217
Figure 18: Photograph of the researcher's notebook showing an illustration of method triangulation idea developments	225
Figure 19: Mind map illustrating the emergence of paradigms in connection to the dimension of confidence and key words from their narratives.....	236
Figure 20: Illustration of the revised and final concept of confidence, illustrating the four paradigms of confidence that bring meaning and understanding.....	239
Figure 21: The new illustration of the concept of confidence adjusted to illustrate the primary concept analysis's model case of Mrs. P.	241
Figure 22: Illustration of the social constructs present in the literature presented on parallel continuums.	250
Figure 23: Illustration the dynamic element of control in context of parallel continuums of the social paradigm.....	266

Figure 24: Interpretation of the Walker (2012) illustration of a unifying theory of control.....267

Figure 25: Proposed post-doctoral plans for the concept of confidence.281

Figure 26: Illustration of the new concept of confidence and here considering the connection to the concepts of social isolation and loneliness284

List of Tables

Table 1: The Systematic Review's PICO. (Lockwood et al., 2015)	66
Table 2: Included studies in the systematic review.	73
Table 3: Quality appraisal for included studies in the systematic review. (Refer to Appendix 1, Appendix III for details of the ten questions)	78
Table 4: Categories and the synthesized finding from the systematic review. ..	80
Table 5: Categories with contextual and dictionary definitions.....	81
Table 6: Recommendations for practice.	87
Table 7: Recommendations for research.	89
Table 8: Model, borderline, related and contrary cases of confidence.....	104
Table 9: Methodological structure for human science research.....	121
Table 10: The methodological approach to interview analysis respecting human science.....	123
Table 11: Phenomenological study inclusion and exclusion criteria.....	131
Table 12: Criteria for Evaluative Appraisal of Phenomenological Studies.....	139
Table 13: Characteristics of study participants.....	142
Table 14: Data extract from the Individual interview analysis – describing the phenomena and identifying the incidental themes (Participant 02)	147
Table 15: Data extract from the meaning and understanding review to evidence the incidental theme (Participant 02).....	149
Table 16: Data extract of the guided existential inquiry (Participant 02).	153

Table 17: Exploring the epoché and conducting the reduction – a methodological examination of separation and the reductive reflection of the emerging phenomena (Participant 02).....	155
Table 18: Unique incidental themes extracted from the phenomenological interviews with older people.....	182
Table 19: The dimension of social connections.	190
Table 20: The dimension of fear.	196
Table 21: The dimension of independence.	199
Table 22: The dimension of control.....	202
Table 23: Summary of findings from stage's one, two and three of this study.	221
Table 24: Definitions of different types of control.	262
Table 25: The theoretical propositions underpinning Walker's unifying theory of control.	269
Table 26: example of how the action cycle of the knowledge to action framework could be utilised to apply a service based change adopting the concept of confidence.	279
Table 27: Table summarising overall study strengths and limitations.	295

CHAPTER 1:

EXPLORING THE NOTION OF CONFIDENCE:

INTRODUCTION

***“No matter what people tell you,
words and ideas can change the world.”***

Robin Williams (actor and comedian)

This thesis is set in the global context of healthcare being delivered to an increasing older population. The oldest-old in our societies often live with frailty, their confidence or loss of it has a significant ability to enhance life in old age, or to devastate it. The word confidence appears to connect to the seventeenth century expression *diffidence* meaning ‘distrusting oneself’, however, in contemporary healthcare there is an urgent need to truly understand its meaning and wider construct. The idea of exploring the understanding and meaning of confidence from the perspective of older people living with frailty may not *change the world*. It is hoped that, by enabling a concept, that is better understood, to be defined, created and shared, it will influence clinical practice and outcomes for older people. This thesis presents the exploration and development of this concept and presents important findings to the clinical and academic healthcare communities.

My epistemic position

Amongst the essential elements in human science is the self-awareness of how our opinions, beliefs, certainties and realities enable us to understand how we interact with and respond to each other. McAllister (2016) describes these elements and promotes the practitioner's perspective as being crucial in the search of knowledge. This reinforces the importance of presenting my personal experience in the introduction chapter of this thesis.

As a Consultant Nurse in Older People's Care I have often heard confidence spoken about in the context of the patients I care for, those older people living with frailty. When you talk about this term 'confidence' to these patients, their carers and families, and with their healthcare professionals, it opens up a world of viewpoints and conjecture. These viewpoints are full of interesting ideas and promote thoughts about what confidence really means. McAllister (2016) writes of the epistemic stance. For me, this is informed by influences from academia on my career; following my *traditional* route to nurse registration in the late eighties, through post-registration education in the nineties and my higher degree studies shaped by social scientists in the noughties. Finally, in the twenty-tens, exposed to human science research which was brought to life by Max van Manen (van Manen, 1990, van Manen, 2006, van Manen, 2014).

I am committed to a Nursing Praxis – the thoughtful action of the art and science of nursing (Burns and Bulman, 2000). This thoughtful action resonates with the caring nature and natural attitude of nursing. From my early career as a Primary Nurse on a Younger Disabled Unit, my nursing praxis emerged, much as it did in our wider profession, as an emancipatory force against the positivist

traditions of medicine, picking up on the then disconnection between education and practice. This was charged by the familiar knowledge and practice gap language used from the late eighties (Rolfe, 1993, Burns and Bulman, 2000), which today is threatened to receive paradox status if no action is taken to view seriously the implementation sciences (Westerlund et al., 2019).

My mid-career was in rehabilitation nursing and older people's care, where I worked as a consultant practitioner, responsible and leading nurse-led intermediate care services as they started and evolved. This was the nexus between primary and secondary healthcare that was targeted at our aging population (Department of Health, 2001). Confidence building was a recognised aim of these new evolving services:

Intermediate care should be used as an opportunity to maximise people's physical functioning, build confidence, re-equip them with the skills they need to live safely and independently at home, and plan any on-going support needed. (Department of Health, 2001: 46)

However, looking into the literature it was found to be only lightly interspersed with vague and ambiguous references to confidence in connection to lived experience of older people. No theory to inform practice. As I explored further the research options available to seek understanding, I was quickly confronted with a frustrating range of theoretical language and complexity of terminology that I felt to be a barrier to accessing insight into any evidence-base. I became worried about the intellectually inaccessibility of knowledge in my professional world and this challenged my nursing praxis. Then, introduced to van Manen and exploring his ability to reach a human pre-conscious world of lived understanding excited me, it opened up new possibilities and opportunities.

This interest in the notion of the confidence of older people living with frailty and these academic influences all sat within the real world and practice-based reality in which I lived and worked. Now as a senior clinical consultant practitioner and academic, I wished to address this.

Thus, this sets my personal and professional context for this thesis - my epistemic stance.

A brief synopsis of the problem

Health and social care systems world-wide cannot ignore the fastest growing section of the population, those individuals aged 85 years and over – the oldest-old (World Health Organization, 2011). One in four of this oldest-old population will live with frailty (Collard et al., 2012), a syndrome linked with growing impairment and disability (Clegg and Young, 2011). Maintaining independence, positive physical and mental well-being are seen as essential to preserving health and to prevent frailty as we age. Beswick et al. (2010) report that one in twenty over 65-year-olds will experience *catastrophic decline* in their mobility each year. Predictors of decline are older age, previous self-report of deterioration including hearing loss, low functional reserve, psychological problems and low levels of social engagement (Beswick et al., 2010: 128-129). The strongest evidence-based intervention for such older people living with frailty focuses on a process called Comprehensive Geriatric Assessment (British Geriatric Society, 2012, Ellis et al., 2017). Comprehensive Geriatric Assessment is defined as a multidimensional, interdisciplinary diagnostic process used to co-ordinate geriatric care. It is a process that combines

interdisciplinary assessment; geriatric medicine expertise; identification of medical, physical, social and psychological problems; and the formation of a plan of care including appropriate rehabilitation goals (Ellis et al., 2017).

The proposition of this thesis originates from the need to understand what confidence means to older people living with frailty and how it fits within this complex inter-related world. The idea that confidence has a part to play in maintaining independence sits directly within the UK government's intermediate care policy (Department of Health, 2001, Department of Health, 2009).

However, insight into the practicalities of policy implementation in this regard is absent from the literature and the contextual meaning of what confidence really is, is not clearly understood. Nicholson et al. (2012b) identify *loss of confidence* as a recurrent phase being used in their study exploring the experiences of older people living with frailty over time. However, clarity on meaning and understanding from the perspective of the older person were not elucidated. This pattern is found across the healthcare literature, where descriptions of confidence are ambiguous, often researcher-centric, and are rarely from the first-person perspective, that is of the older persons themselves. The literature has its strongest connection to the term confidence within quantitative research studies related to falls. This is associated with the measurement of confidence and of a person's fear of falling (Gillespie et al., 2013). The lack of published meaning and understanding to-date magnifies this important knowledge gap.

The impact of confidence

An anecdote (Box 1) shared by a work colleague and captured at the start of this study illustrates the impact of confidence growth and loss from their

perspective of an older person living with frailty (anonymised and shared with permission to publish).

Box 1: A perspective on confidence and frailty:

“My father’s gradual loss of vision over the last few years, initially gave him a noticeable increase in his confidence and physical abilities. This impacted positively on him mentally as he came to grips with macular degeneration. In part, he knew what the diagnosis was and he was being supported by clinic staff and friends and family to deal with the problems it was leaving him with. He had a new desire to get out and about more, while he had vision. His physical activity increased, he became much more sociable...”

The work colleague described a personal worry about his father being over-confident at times and believed:

“...this over-confidence led to the significant setback following a fall in the street. The fall was linked to his deteriorating eyesight. This completely took away the confidence he had. Everyone around him saw it and in turn this slowly eroded any confidence in getting out of the house. I saw him slowly withdraw inwardly.

Looking back, this was the turning point in his physical and mental health decline, he is now very dependent on carers and lives in a care home.”

Asking about confidence’s connection with frailty, the work colleague said:

“I definitely see the connection between the increasing frailty I saw in my father over this time as his confidence was eroded and he slowly withdrew. He is so frail now in that care home.”

(Personal Communication, 2015)

Individually we may hear the word ‘confidence’ spoken, we may verbalise it with others and of course feel and experience it, in empathy with the older person. However, what we hear, speak or feel seems nebulous, individual, subjective and personal. As such its impact may not be respected or valued until light is shone upon it, or we directly ask and discover it.

With such high stakes on the limited time the oldest-old people have with us and surmising that the impact of confidence will often have significant repercussions on mental well-being and physical health, it is surprising that clarity on meaning and understanding of confidence in relation to this oldest-old population evades us in academia and in practice.

Purpose and significance of the study

Responding to an increasing aging population in the UK, there are multiple socio-economic factors connected to poor well-being, ill health, disability and frailty that need tackling (Centre for Ageing Better, 2019). In healthcare, this impact is relevant and very much felt across the National Health Service (NHS England, 2019b). As such, the need to understand and develop impactful confidence building care is as important today as it was nearly twenty years ago, when intermediate care services were emerging (Department of Health, 2001). The new NHS Long Term Plan calls for action over the next five years to increase further the capacity and responsiveness of intermediate care services, both its crisis response and its rehabilitation and reablement elements (NHS England, 2019b). Therefore, the need to understand more about what confidence means, both in terms of confidence loss and confidence building, is vital, as we continue to explore and devise effective interventions to address the

incidence and progression of frailty in older people. In order to educate healthcare professionals and inform practice, it is imperative that interventions are built upon a strong and credible evidence base that is effectively translated into practice (Grimshaw et al., 2012). The lack of narrative and a conceptual construct of confidence impedes evidence informed education and leaves practitioners unaware of how to effectively change their practice to benefit older people.

The aim and objectives of the research study

The aim was:

To explore and develop a concept of 'confidence' in the context of older people living with frailty and consider implications for practice.

The objectives were:

1. To meta-aggregate qualitative evidence relating to the meaning and understanding of confidence experienced by older people living with frailty.
2. To synthesise contemporary evidence to produce a construct of what 'confidence' is, in the context of older people living with frailty.
3. To conduct a phenomenological enquiry to understand the lived experience of the phenomena of confidence with older people and its contextual relationship with frailty with older peoples, with their carers and with healthcare professionals.

4. To undertake an evaluative review, considering all data collected in the study to create the final concept of confidence; and consider implications for practice and future research.

Study design and theoretical framework

Graham et al. (2006) present the Knowledge to Action Framework. This was used to shape and inform this study and identify a pragmatic way forward, from a very open-ended starting point to a meaningful conclusion. Synthesising and creating knowledge to inform practice is a science; the Graham et al. (2006) framework brings together the multifaceted fields of implementation science. However, despite being one of the most cited conceptual frameworks for knowledge translation in the literature, highlighted by Field et al. (2014) in a systematic review of its practical use, they identified significant variation in application across studies; from single citations, to being fully embedded within implementation studies. Within this context it became valuable to explore specific aspects of knowledge generation to be impactful for healthcare professionals to adopt in practice to improve outcomes of older people.

At the centre of the Knowledge to Action Framework is a 'Knowledge Funnel' (Figure 1) where knowledge is created for implementation or action (Graham et al., 2006:18). Primary research findings form the focus at the top of the funnel. However, for more practical purposes, some level of further analysis and interpretation is often needed. Thus, in the knowledge creation funnel, a secondary level of data aggregation is recognised, often conducted through systematic reviews. These new data descend the funnel and at each stage, these are sense-checked or tested with stakeholders, known as tailoring

(Graham et al., 2006). The final stage, at the bottom tip of the funnel, is where one finds finalised products or tools to aid implementation and transference of knowledge to practice.

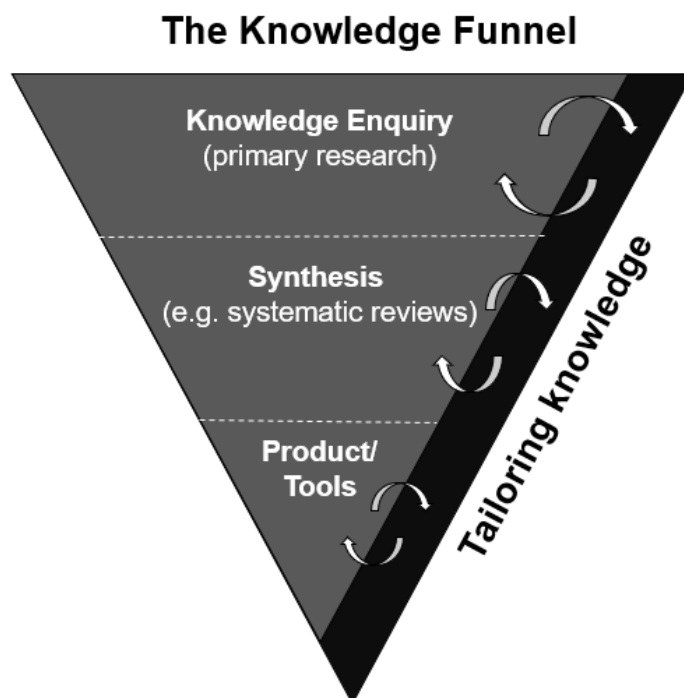


Figure 1: The Knowledge Funnel, image adapted from Graham et al. (2006).

At this point, the second fundamental element of the Knowledge to Action Framework takes prominence; the Action Cycle (not illustrated). This takes practitioners on the implementation journey, through a range of dynamic stages: adapting the knowledge to the local context; assessing barriers to knowledge use; selection, further tailoring and implementation of the intervention; monitoring knowledge use; evaluating outcomes; sustaining knowledge use and; back to review – or where the cycle started – identifying the problem,

which may then be redefined on a second action cycle (Graham et al., 2006: 20-21).

The knowledge creation funnel informed this research study's design. A four-stage interpretivist study was created (Figure 2), based on multiple qualitative methodologies to explore the phenomena of confidence:

- a meta-aggregative systematic review of qualitative evidence;
- an up-to-date literature review to inform a concept analysis;
- a phenomenological enquiry to understand the lived experience of confidence; and
- a methodological approach to evaluate synergy across the three qualitative study's findings.

Doctoral Study	Stages	Study Description	Methodology	Knowledge to Action Framework	Knowledge Creation
	Systematic review	Meta-aggregation of contemporary qualitative evidence	JB1 Systematic Review		
	Primary concept development	Concept development from contemporary qualitative literature	Walker and Avant method		
	Phenomenological enquiry	Interpretive phenomenology (participant study)	van Manen's methodological structure for human science research		
	Study's findings review	Final concept production	Method Triangulation		

Figure 2: The four stage interpretivist study design.

An interpretivist perspective

In developing the systematic review protocol (Underwood et al., 2015), it became clear that insight into the meaning and understanding of confidence

from the perspective of older people was going to be very limited, thus a wider and inclusive interpretivist study was designed to address this important gap in knowledge. This methodology is supported by Braun and Clarke (2013) who assert that research study design is influenced by the method of data analysis that is most appropriate to the research question being asked. In the context of the Knowledge to Action framework, the design adopted multiple qualitative methodologies to explore the phenomena of confidence and to sequentially create an understanding of confidence through the lens of older people living with frailty (Figure 2). This inclusive research approach relies on multiple viewpoints and perspectives to unearth this complex phenomenon (Creswell, 2009: 8-9). These multiple perspectives are reflected in the choice to start the study with a meta-aggregative review of qualitative data, and these naturally include a range of methodological studies in order to capture the whole of a phenomenon of interest (Aromataris and Munn, 2017). An initial targeted review of the literature to meta-aggregate the voices of older people talking of confidence within the qualitative literature utilised the Joanna Briggs Institute systematic review methodology (The Joanna Briggs Institute, 2015a, Lockwood et al., 2017), illustrated in the first study stage (Figure 2) and addressed research objective one. The study's second stage took a broader look at confidence in the context of older people living with frailty. This followed concept analysis methodology of Walker and Avant (2014) and addressed research objective two. The lived experience of older peoples living with frailty and experiences of their carers and healthcare professionals was exposed using a human science phenomenology, described by van Manen (1990, 2014).

This formed the third study stage and met the expectations of research objective three.

This incremental approach to addressing the contemporary healthcare literature gap is justified in the context of Creswell's (2007) constructivist worldview of qualitative research. Here, one searches for understanding and meaning, constructed by humans engaging in the real world. The context of understanding has to be in the social and historical environment of the participant and their personal lived experience. This social constructivism sees the social world in which we live (constructed) through language, presence, and social processes (Braun and Clarke, 2013). The process is intuitive, with the enquirer generating some notion of meaning to achieve understanding through reflective interpretation. Therefore finally, the association between these three study outcomes is assessed using method triangulation (Polit and Beck, 2012) in the final study stage and addressed research objective four, to create the final conceptual construction of confidence.

This final section of this introduction chapter describes how the rest of this thesis will evolve and present its findings.

Overview of the thesis

Chapter 1: Exploring the notion of confidence: introduction

This first chapter has introduced the thesis, and included a statement on the researcher's epistemic position; an overview on the background to the problem; the purpose and significance of the study, including the study question; and a detailed overview of the study design.

Chapter 2: A historical perspective of frailty: the last 25 years

Chapter 2 abridges the frailty literature over a period of 25 years from the publication of the first significant model of frailty that still shapes frailty care today. The chapter outlines key developments over this period to inform later analysis and discussion of the findings.

Chapter 3: The meaning of confidence for older people living with frailty: a qualitative systematic review

Chapter 3 presents the first stage of the study, a systematic review of the literature. This is published work and includes the final manuscript of the published article of the qualitative systematic review and data meta-aggregation submitted for publication. It concludes by calling for greater clarity to be provided to the concept of confidence.

Chapter 4: A concept analysis of confidence related to older people living with frailty

Chapter 4 presents the final submitted manuscript of the published article of a wider literature review that informed the second stage of the study: the primary development of a concept of confidence.

Chapter 5: Understanding the concept of confidence using phenomenological enquiry: study design

Chapter 5 focuses on the research study design and methodological approach adopted to answer the third study stage – the interpretivist phenomenological enquiry. All aspects of the participative study protocol are presented.

Chapter 6: The lived experience of confidence: findings from the phenomenological enquiry

Chapter 6 presents analysis and findings from the third stage of study, the phenomenological enquiry. Four essential themes of confidence, that emerged as seen through the lens of older people living with frailty, are presented.

Chapter 7: Method triangulation: formulating the final concept

Chapter 7 presents the methodological framework and final analysis of all the research study findings, considerations regarding the weight of the various contributions and the strength of evidence, and illustrating new discoveries and conceptual insight.

Chapter 8: The paradigms of confidence: contribution to knowledge

Chapter 8 holds a discussion that considers the concluding study's findings in the context of contemporary frailty models and associated theoretical constructs. Implications for future practice, research and education are explored as a pragmatic interpretation of the findings is taken. An assessment of the study's trustworthiness concludes this chapter.

Chapter 9: The concept of confidence of older people living with frailty: the final synopsis

Chapter 9 presents the overall conclusion of this thesis and offers a pragmatic view on how its final concept of confidence will influence clinical and academic practice.

CHAPTER 2:

A HISTORICAL PERSPECTIVE OF FRAILTY: THE LAST 25 YEARS

This chapter does not purport to completely summarise or do justice to a quarter century of progressive clinical and academic work in frailty recognition and research, following the publication of the Rockwood et al. (1994) paper 25 years ago. Rather, this chapter will abridge this period with an outline of key developments to inform later analysis and discussion chapters. This is important when considering confidence, as it emerges from the researcher-led studies contained in this thesis. This thesis postulates a probable intrinsic link between the two – frailty and confidence. By having a wider awareness of the emergence of frailty's theoretical presence today, it helps to contextualise and conceptualise the lived experience of confidence through the lens of those living with frailty.

Early model developments

The Rockwood et al. (1994) paper; *Frailty in elderly people: an evolving concept*, defined a model that went on to stimulate significant international debate and activity in a search for a consensus definition. Some twenty years on, the paper of Clegg et al. (2013); *Frailty in elder people*, cited in Chapters 3 and 4 of this thesis, presents a contemporary position on frailty model theory.

This later paper summarised the two predominant models: *the phenotype model* (Fried et al., 2001) and the *cumulative deficit model* (Rockwood and Mitnitski, 2007, Rockwood et al., 2005, Mitnitski et al., 2001), (Clegg et al., 2013: 755-756). A significant change today from then, is seen in the increasing apparent intolerance in the use of the term *elderly*, and even challenges made to the use of the term *frailty* itself (Falconer and O'Neill, 2007, BritainThinks, 2015).

A dynamic model of frailty appears in the Rockwood et al. (1994) paper. This was described as *a complex interplay of assets and deficits, “medical” and “social”, that maintain or threaten independence, and that the model is dynamic, and changes in status can be recognized by adjusting the weights of the various assets and deficits* (Rockwood et al., 1994: 490-491).

Rockwood et al. (1994) explores Brocklehurst's *model of breakdown* (1985) (Figure 3), a model reflecting the dynamic balance between biomedical and the psychosocial aspects of the older person living with frailty.

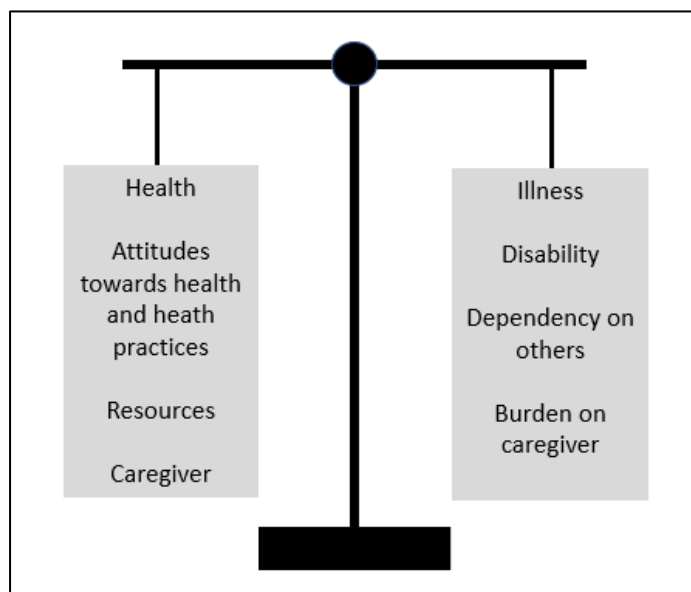


Figure 3: Representation of the scales illustrating the dynamic model of frailty from the Rockwood et al. (1994) paper.

These balancing assets, for example health, and deficits such as disability, become precariously balanced with age. The paper goes on to suggest that those whose balance is in favour of assets remain living in the community, those whose scales tip into deficit *are the frail elderly people who live in institutions* (Rockwood et al. (1994: 490). Their paper goes on to evidence this model.

Whether today, with developing health and care services around the evidence base, such polarised distinctions can be made is questionable. However, Rockwood et al. were committed to make frailty understandable for practitioner and policy maker alike. Rockwood and colleagues achieved three fundamental developments, recorded in the following three papers. The first was a rules-based definition of frailty (Rockwood et al., 1999), whereby patients were screened against criteria for Geriatrician intervention. Those who were increasingly graded on level of dependency, if requiring personal care, bowel and bladder care and were cognitively impaired, would trigger the highest score (an accumulation of deficits). The next development was a more sophisticated mathematical modelling approach, based on counting a patient's clinical deficits such as: signs and symptoms, functional impairment and abnormal laboratory results (Rockwood et al., 2002). This was also known as the Frailty Index (Jones et al., 2004, Rockwood et al., 2005). The third development was the creation and validation of a Clinical Frailty Scale (Rockwood et al., 2005). This Scale was devised for practitioners to stratify patients as to their relative degree of

vulnerability, defining this as *their risks of death and of entry into an institutional facility* (Rockwood et al., 2005: 489-490).

Over this last 25 year period there was a distinct focus on *deficit* and *accumulation* that stemmed from these early definitions and influential model developments from the Canadian Rockwood-led teams. From this work, the Rockwood model attracts the label *cumulative deficit model* (Clegg et al., 2013: 755), despite its early assertion as an asset and deficit model.

At a similar time in the United States of America (US), the *phenotype model* of Fried et al. (2001) developed from a cardiovascular health study and was subsequently published. This model is an association between five physical or biomedical measures and age. These are: weight loss, self-reported exhaustion, low energy expenditure, slow gait speed, and weak grip strength. Its premise was that the relationship between age and these slowing factors are exponentially linked. This model is often cited in contrast and opposition to the Canadian work led by Rockwood. A key criticism of the phenotype model reflects its physical bias and that it does not consider the person beyond the corporeal. For example, the significance of cognitive impairment, a highly prevalent condition associated with functional decline and disability in this oldest-old population (Rothman et al., 2008) has not been taken into account. Interestingly, later in a paper addressing the concept of frailty, Fried demonstrates a flexibility for her rigidly referenced seminal work. In this paper, *Untangling the Concepts of Disability, Frailty, and Comorbidity*, Fried et al. (2004) argue that these three terms are commonly used interchangeably to identify a physically vulnerable subset of older adults requiring enhanced care. Fried et al. defines frailty in this paper as a:

Clinical syndrome characterized by multiple characteristics including weight loss, and/or fatigue, weakness, low activity, slow motor performance, and balance and gait abnormalities. Potential cognitive component. (Fried et al., 2004: 260)

This partial consideration of a wider interpretation of frailty came by garnering a consensus view of geriatricians across six academic medical centres in the US. This triggers the start of the next phase in frailty developments.

In search of consensus

Over €500,000 was invested to reach a consensus on an operational definition of frailty as the first decade of the 21st Century concluded (European Commission, 2010). A modified Delphi process was used and reported (Rodríguez-Mañas et al., 2012). Consensus was reached on recognising the importance of defining frailty in clinical settings and the need for a clear conceptual framework. Unfortunately, no other consensus was reached. Six areas achieved the threshold consensus of 80% or greater concluding that frailty is: a clinical syndrome; is not a disability; increases vulnerability in which a minimal stress can cause functional impairment; might be reversible or mitigated by interventions; is mandatory for health care professionals to detect as quickly as possible; is useful in both primary and community care settings. (Rodríguez-Mañas et al., 2012).

Morley et al. (2013) picked up the baton and, in a *Call to Action*, they achieved their goal in defining physical frailty. The group defined physical frailty as:

a medical syndrome with multiple causes and contributors that is characterized by diminished strength, endurance, and reduced

physiologic function that increases an individual's vulnerability for developing increased dependency and/or death. (Morley et al., 2013: 2)

The literature's disappointingly dominant focus, to this point, on the physicality of frailty and health was commented on by Nicholson et al. (2013). At the same time further consensus events were taking place, such as the European consensus on sarcopenia (Cruz-Jentoft et al., 2010). Sarcopenia is a *progressive and generalised skeletal muscle disorder that is associated with increased likelihood of adverse outcomes including falls, fractures, physical disability and mortality* (Cruz-Jentoft et al., 2019:18). Cruz-Jentoft et al. (2010) compared sarcopenia with syndromes affecting older adults, including frailty. They recognised the important physical connection to the frailty phenotype work of Fried et al. (2001), but then went beyond this singular dimensional view to see an overlap between sarcopenia and frailty. They stated that *most frail older people exhibit sarcopenia, and some older people with sarcopenia are also frail. The general concept of frailty, however, goes beyond physical factors to encompass psychological and social dimensions as well, including cognitive status, social support and other environmental factors* (Cruz-Jentoft et al., 2010: 415). This view remains unchanged in their recent consensus update (Cruz-Jentoft et al., 2019: 24).

Despite the growing consensus on sarcopenia, Bauer and Sieber (2008) argued that the focus on the emergence of frailty concepts would always dominate, because, for the practitioner, frailty has a greater clinical orientation (beyond physicality) that will always overshadow that of sarcopenia's concepts; a professional view that still exists today (Witham and Stott, 2018).

Later model developments and concepts of frailty

As frailty models continued to develop in the second decade of the 21st Century, their relevance to clinical practice grew and research impact matured (Dent et al., 2016). This paper summarises an up-to-date position with frailty models and early concepts. These included: Fried's frailty phenotype; Rockwood and Mitnitski's Frailty Index; the Study of Osteoporotic Fractures Index; Edmonton Frailty Scale; the Fatigue, Resistance, Ambulation, Illness and Loss of weight (FRAIL) Index; Clinical Frailty Scale; the Multidimensional Prognostic Index; Tilburg Frailty Indicator; PRISMA-7; Groningen Frailty Indicator, Sherbrooke Postal Questionnaire; the G rontop le Frailty Screening Tool and the Kihon Checklist, among others (Dent et al., 2016: 3).

This last decade was driven by frailty recognitions and identification to drive potential interventional studies. Crome and Lally (2011) connected frailty to the modern-day geriatric giants: immobility, instability, incontinence, intellectual impairment and iatrogenesis, all well researched areas of intervention from a practitioner's perspective. This may have been what prompted, as Rahman (2019) notes, the next development in the frailty story as the British Geriatric Society introduced a new conceptual angle – describing a range of frailty syndromes based on these giants (British Geriatric Society, 2014). The newly defined syndromes of frailty were falls, immobility, delirium, incontinence and susceptibility to the side effects of medication, principally a rebranding exercise. There were later transferred to its 'Fit For Frailty' series (British Geriatric Society, 2017, British Geriatric Society, 2018). Xue (2011) made this connection to frailty syndromes at a similar time and argued that the work on frailty to-date

had responded to the measuring of frailty, rather than developing meaningful conceptual constructs. Xue (2011) conceptualised frailty and argued for a continued focus on the five elements of the physical phenotype model, as its ease of application makes it more appealing for clinical use compared to Frailty Index of Rockwood et al., that contains up to 70 items to score against. De Lepeleire et al. (2009) argued that conceptually, frailty fits well with the biopsychosocial model of general medical practice and propositions useful tools for practitioners and health care commissioners to target resources at an ageing population. In 2017, Gobbens et al. (2017) presented the diagnostic Tilburg Frailty Indicator, based on a multidimensional approach to frailty which assesses: physical, psychological, or as they report, psychologic, and social aspects of human functioning. Their conceptual model focuses on the decline across the three dimensions. For example, in the psychologic frailty domain, it captures any decline in cognition, mood and coping. The physical frailty element describes decline in nutrition, mobility, physical activity, strength, endurance, balance and sensory function. Finally, the social frailty domain focuses on decline in social relations and support. All three domains are interconnected in the model. A further conceptual model of frailty is described by Sieber (2017), this one stemming from the physical phenotype connected to sarcopenia but reflecting other essential dimensions of frailty with the psychological and the social, alongside the physical. This model is diagrammatically represented by three interlocking Venn circles. Figure 4 illustrates this in the context of describing a concept of frailty.

As the cascade of conceptual models continued to emerge, a commonality among them was the persistent presence of the three core domains: physical, psychological and social or a biopsychosocial framework. In turn these connect to such practice-based developments, those that evolved the fundamental pillar of geriatric medicine today, that of Comprehensive Geriatric Assessment or CGA.

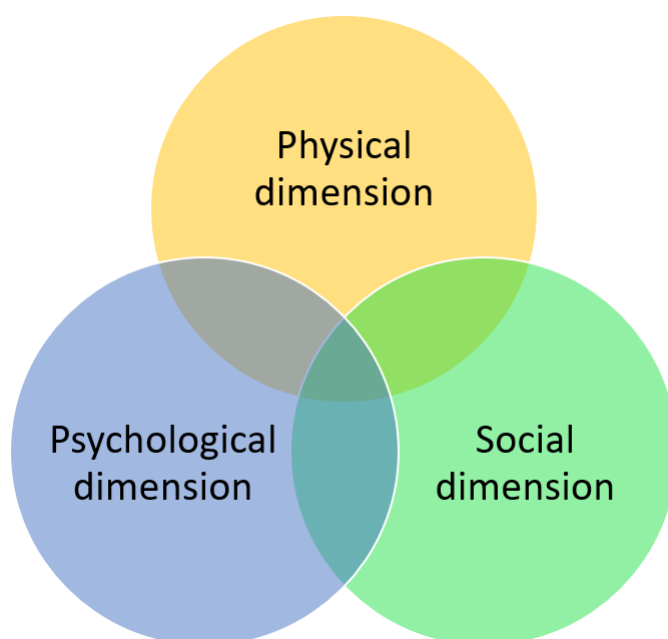


Figure 4: Venn diagram illustration the interlocking physical, psychological and social dimensions of frailty.

Comprehensive geriatric assessment is *a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological and functional capabilities of an older person with frailty, followed by implementation of a co-ordinated and integrated plan for treatment and follow-up* (Gladman et al., 2016: 194). In 2004, the connection between frailty and the Comprehensive Geriatric Assessment was identified as a way of operationalising the Frailty Index (Jones

et al., 2004). CGA continues to be the foundation of geriatric medicine practice and is a robustly evidence based intervention used to affect outcomes for older people living with frailty in hospital settings (Ellis et al., 2017); and for surgery (Eamer et al., 2018).

Turning full circle

This reconnection to ensuring models and concepts of frailty are of practical use to the practitioner and reflecting frailty's biopsychosocial presence takes us full circle. Sight of these were reduced but not fully lost in the middle years, when physicality seemed to predominate the multitude of frailty research and reported activities over this time. Now the refreshing work by Rahman (2019) may provoke and stimulate a fresh discourse to take us forward into the 2020's. A full circle is turned as he draws our gaze to frailty and intensifies our focus on people's assets. Reinforcing assets, as opposed to the more familiar focus on deficits, brings us back to reflect on Brocklehurst's scales (Figure 3), balancing health assets with illness deficits. Assets are freshly presented from the desirable prospect of self-intervention and self-management as the presence of resilience in the frailty landscape is considered (Rahman, 2019). He promotes the frailty fulcrum (Moody, 2016), a multidimensional model of frailty. Holistic components of the frailty fulcrum include:

- Social environment, including family and friends and the communities we live in
- Physical environment, particularly our homes
- Psychological status, which comprise specific conditions, such as anxiety, or more general feelings like confidence, fear or motivation

- Long-term condition management, such as diabetes, heart or respiratory diseases, or cognitive impairment
- Acute health problems, for example infections or injuries
- Systems of care, both provision and delivery, impacting on well-being.

Moody (2016) states that *factors within each of these domains can either promote individual resilience or create individual vulnerability* (online reference).

The balance between resilience and vulnerability create the condition of frailty.

Rahman (2019) expands on this and defines frailty as *a complex and multidimensional state linked to other concepts including multi-morbidity, disability, dependency and personal resilience*. Rahman (2019: 1)

He does not dismiss the cumulative deficit model, however he does promote frailty as *a complex interplay of a person's assets and deficits as a result of a combination of factors, such as age, gender, lifestyle, socioeconomic background, comorbidities and affective, cognitive and sensory issues*.

(Rahman, 2019: 1)

This definition has many inter-related elements, one of which stands out that requires further clarity: that of resilience. According to Rahman (2019), personal resilience is a psychological construct present in adversity, when an individual adopts a positivity to overcome the challenges and barriers faced. This personal asset, suitable in response to a crisis or an acute physical stressor, is linked to a person's vulnerability. Rahman (2019) cites the taxonomy of Rogers et al. (2012), setting out vulnerability as a component of inherent, situational and pathogenic states that exist within a temporary or enduring state. These related

connections to frailty emerge in this thesis, therefore contextual understanding here will support clarity in the later analysis and discussion sections.

The asset model accentuates the positive, and Rahman explains the model is about *positive ability, strength, mobility, and capacity to identify problems and activate solutions, which promote the self-esteem and motivation of individuals and communities, leading to less reliance on professional services*. (Rahman, 2019: 2)

These element link to resilience of the individual. Rahman (2019) notes the importance of asset models that focus on elements of successful ageing, a shift away from disease status and functional decline to a multi-dimensional health status which encompasses physical functional psychological and social health. This '*activation of solutions*' resonates with current UK Government health policy, focusing on Patient Activation Measures. The NHS Long Term Plan (NHS England, 2019b) promotes shared decision making between patient and practitioner (Ham et al., 2018), the basis of which are Patient Activation Measures (PAMs) (Hibbard and Gilburt, 2014). However, recent research from the Netherlands reports low levels of PAMs in older people with frailty (Overbeek et al., 2018). This is probably the reason for the attention in this field and is likely to connect to significant further research.

Throughout the last 25 years, the increasing impetus for policy maker influence has driven the growing maturity in frailty conceptualisation, in nurturing a world-wide interest and influence across the aging world's population. In the UK, it was in 2014 that frailty was formally adopted into national policy by the Department of Health and later recognised as a long-term condition (NHS England, 2014, NHS England, 2017, NIHR, 2017, Skills for Health, 2018). Other

frailty citing publications from NHS England include a series from the National Clinical Director for Integration and Frail and Elderly Care (Young, 2015a, Young, 2015b, Young, 2015c, Young, 2015d) and National clinical guidelines (NICE, 2016). This arrival into public policy cements a frailty focused future in healthcare and research politics, grounded in the growing demographic changes worldwide (World Health Organization, 2011).

This chapter has presented a brief historical overview of frailty models and concepts, focusing on those present at the time this research study was created. It has focused on the underpinning literature relating to confidence in the context of older peoples living with frailty. This thesis will now proceed with two chapters presenting the outcomes of the first two stages of this research study: final published green manuscripts further exploring the literature to understand the concept of confidence.

CHAPTER 3:

THE MEANING OF CONFIDENCE FOR OLDER PEOPLE LIVING WITH FRAILITY: A QUALITATIVE SYSTEMATIC REVIEW

UNDERWOOD, F., BURROWS, L., GEGG, R., LATOUR, J. M. & KENT, B. 2017. The meaning of confidence for older people living with frailty: a qualitative systematic review. JBI Database of Systematic Reviews and Implementation Reports, 15, 1316-1349. DOI: 10.11124/JBISIR-2016-002951

Published manuscript contribution statement

Based on the International Committee of Medical Journal Editors (2018) recommendations:

Underwood, F. 80%

Co-conception; design of the systematic review; acquisition, analysis and interpretation of data; drafting the work and revising it critically for important intellectual content; final approval of the version to be published.

Burrows, L. 5%

Analysis of data and final approval of the version to be published.

Gegg, R. 5%

Data acquisition and final approval of the version to be published.

Latour, J.M. 5%

Revising it critically for important intellectual content and approval of the version to be published.

Kent, B. 5%

Co-conception; revising it critically for important intellectual content and approval of the version to be published.

Introduction

This chapter presents a green final manuscript of a published paper that fulfils the first stage of the study (Figure 5).

Doctoral Study	Stages	Study Description	Methodology	Knowledge to Action Framework	Knowledge Creation
	Systematic review	Meta-aggregation of contemporary qualitative evidence	JB1 Systematic Review		
	Primary concept development	Concept development from contemporary qualitative literature	Walker and Avant method		
	Phenomenological enquiry	Interpretive phenomenology (participant study)	van Manen's methodological structure for human science research		
	Study's findings review	Final concept production	Method Triangulation		

Figure 5: Illustration of the four-stage study design highlighting the study's first stage, the systematic review.

The publication uses United States English language and spelling. Appendices referenced within this manuscript are available in Appendix 1 of this thesis as they were finally submitted.

The meaning of confidence for older people living with frailty: a qualitative systematic review

Executive summary:

Background

In many countries, the oldest old (those aged 85 years and older) are now the fastest growing part of the total population. This oldest population will increasingly be living with the clinical condition of frailty. Frailty syndromes negatively impact on the person as they do on the healthcare systems supporting them. Within healthcare literature 'loss of confidence' is occasionally connected to older people living with frailty, but ambiguously described. Understanding the concept of confidence within the context of frailty could unlock interventions to meet this growing challenge.

Objectives

The objective of this systematic review was to explore the meaning of confidence from the perspective of older people living with frailty, through synthesis of the qualitative evidence to inform healthcare practice, research and policy.

Inclusion criteria

Types of participants

Studies that included frail adults, aged over 60 years, experiencing acute hospital and or post-acute care in the last twelve months.

Phenomena of interest

This review sought to understand the concept of 'confidence' and its impacts on the physical health and mental well-being of older people living with frailty.

Context

Studies that reported the older person's descriptions, understandings and meanings of confidence connected their frailty or recent healthcare experiences.

Types of studies

This review considered studies of qualitative design and method.

Search strategy

A three-step search strategy was used. The search strategy explored published studies and the grey literature. Publications in English from the last 20 years were considered for inclusion.

Methodological quality

All included articles were assessed by two independent reviewers using the Joanna Briggs Institute Qualitative Assessment Review Instrument (JBI-QARI).

Data extraction

Data were extracted from included studies using the data extraction tools developed by the Joanna Briggs Institute.

Data synthesis

Qualitative research findings were collated using a meta-aggregative approach and the Joanna Briggs Institute Qualitative Assessment and Review Instrument software.

Results

Synthesized findings of this review are drawn from just four research studies that met inclusion criteria. Only six findings contributed to the creation of three categories. These informed a single synthesized finding: vulnerability, described as a fragile state of well-being that is exposed to the conflicting tensions between physical, emotional and social factors. These tensions have the capability to enhance or eroding this state.

Conclusions

Assertions that an understanding of the concept confidence has been reached cannot be made. The reviews' data offer limited insight into the concept of confidence being described by the cohort of older people living with frailty.

Implications for practice

This systematic review found insufficient evidence describing meaning and understanding of confidence. However, practitioners should consider how they identify frailty in practice and respond to older people identifying confidence as a factor in their care and recovery from an acute event.

Implications for research

It is timely and appropriate to pursue a program of research to explore the meaning and understanding of confidence and how clinical practice interventions can enhance outcomes for older people living with frailty.

Keywords

Frailty, Older People, Confidence, Qualitative, Systematic Review

Conflicts of interest

There are no conflicts of interest to declare.

Acknowledgements

Gratitude is extended to the Patient and Public Involvement Group for their commitment and contribution to this review.

This Systematic Review is to count towards a Doctoral award for the first named author.

Summary of findings (Munn et al., 2014)

Population	Older people living with frailty – aged 60 years and older and having recently experienced acute hospital and or post-acute care services in the last twelve months.				
Phenomena of Interest	The concept of 'confidence' and how this impacts on their physical health and mental well-being				
Context	Studies that presented or report the older person's descriptions, understandings and meanings of confidence connected their frailty or recent healthcare experiences.				
Synthesized finding	Type of research	Dependability	Credibility	ConQual Score	Comment
Vulnerability: a fragile state of well-being that is exposed to the conflicting tensions between physical, emotional and social factors. These tensions have the capability to enhance or eroding this fragile state.	Qualitative	Downgrade 1 level*	No change	Moderate	*Downgrade one level due to dependability of primary studies

Background

Worldwide, the number of people aged 65 or older is projected to nearly triple, from an estimated 524 million in 2010 to nearly 1.5 billion in 2050, with most of the increase occurring in developing countries (World Health Organization, 2011). In many countries, the oldest old (those aged 85 years and older) are now the fastest growing part of the total population.

In the UK, over the next 50 years, the number of people aged 65 and over is expected to double. Those aged 85 years and over are set to increase at least four-fold (House of Lords Select Committee on Public Service and Demographic Change, 2013). Population aging will determine future healthcare spending in both developed and developing countries in the decades to come (National Institute on Aging, 2011). The impact of this on healthcare delivery is of great concern to policy makers as well as healthcare providers (House of Lords Select Committee on Public Service and Demographic Change, 2013, Cornwell, 2012, World Health Organization, 2015, Cesari et al., 2016), as this oldest population will increasingly be living with the clinical condition of frailty.

Currently one in four people aged 85 years and over live with frailty (Collard et al., 2012). Frailty is a word growing in our lexicon as it is a phenomenon growing in the evidence base for clinical practice and healthcare policy relating to older people over the last 20 years (Rockwood et al., 1994). Clegg et al. describes two differing academic opinions of this phenomena (Clegg et al., 2013). Frailty can be seen as either a very physical attribute – a phenotype model, described by five measures (weight loss, self-reported exhaustion, low energy expenditure, slow gait speed and weak grip strength). An alternative view of frailty propositions the integration of non-physical susceptibility factors, such as

emotional, psychological and social factors alongside the physical impact of aging - a cumulative-effect framework. The complex nature and presentation of frailty has generated research interest to develop and validate identification strategies to enable future evaluation of effective interventions. One cumulative-effect scale that has gained recent favor because of its ease of practical application is the Clinical Frailty Scale (Rockwood et al., 2005). This scale differentiates nine sub categories of frailty from fit and well to being terminally ill, and gives each a defining high level name, for example: Level 4 – Vulnerable (a pre-frail category), Level 5 - Mild Frailty, Level 6 - Moderate Frailty, Level 7 - Severe Frailty. Frailty progresses over a five to 15 year period, a person's susceptibility to frailty syndromes such as falls, immobility, delirium, incontinence and susceptibility to medication side effects grows over this time (British Geriatric Society, 2014). This resonates with Clegg et al.'s definition of frailty:

an evolving clinical condition due to a consequence of age-related decline in multiple body systems, which results in vulnerability to sudden health status changes triggered by minor stress or events such as an infection or a fall at home, this in turn increases the risk of adverse outcome including delirium and disability. (Clegg et al., 2013: 725)

It is not surprising that these frailty syndromes are the leading causes of acute hospitalization for this patient cohort. Falls presenting to the UK's National Health Service are estimated to cost £1.7 billion per year in hip fracture care alone, as over 60,000 older people fall and fracture a hip each year, that in turn contributes to 14,000 deaths (Royal College of Physicians, 2008). Whereas the financial healthcare costs of a hospitalized patient with delirium are equally high

and are associated with poor outcomes (Inouye et al., 2014), one US study reported a two and a half times greater per day cost than an older patient without delirium (Leslie et al., 2008). With one in eight older patients presenting at emergency departments with delirium and up to half of all hospitalized older patients experiencing delirium, this has a high personal and economic impact (Bogardus et al., 2001).

Overall, hospitalization has a negative effect on older people with frailty. Especially as a result of immobility, sub optimal continence care and nutritional support, the latter specifically impacting in the four weeks following discharge (Zisberg et al., 2015, Lafont et al., 2011). It is suggested that half of all such harms are preventable (Sourd et al., 2015). In a small study, ten days of bedrest for an older person with frailty led to the equivalent of a decade of muscle aging, researchers conclude that deconditioning and immobility in hospital is dangerous (Kortebein et al., 2008).

The effect of physical well-being is more clearly understood than that of mental well-being at this time. Understanding the concept of confidence, in relation to this population of older people living with frailty and in the context of acute hospitalization and post-acute care, becomes a high priority for service providers and policy makers. However, within the healthcare literature the concept of confidence, in this context, is hard to unearth and seems ambiguous and mostly researcher/author-centric in description when found. An initial search (MEDLINE and CINAHL) of the literature to find clarity on what confidence means and is understood by older people living with frailty, and how individuals and practitioners are conceptualizing and using such knowledge was undertaken. No systematic reviews exploring confidence, frailty and mental

well-being or physical health were identified. An individual's confidence is observed in the healthcare literature in one of only a few ways: relating to a concrete or conceptual loss; in the falls literature linked to a person's fear of falling; or connected to one or two mental health and wellbeing concerns. These themes are expanded on here:

Nicholson et al. (2012b), exploring the experiences of older people living with frailty, identified 'loss of confidence' as a recurrent phase being used in the context of an individual's dealings with the impact of their physical health deterioration over time and on their psychological and social well-being. By far the greater literary content relating to confidence and loss sits outside qualitative research paradigms, but may give contextual insight to aid future search strategies, these included: Viljanen et al. (2013) report on the impact of sensory loss and how the fear of falling jeopardizes an individual's confidence; whilst loss of social contact/social isolation/loneliness are reported by a number of researchers (Cattan et al., 2011, Dean, 2014, Iecovich and Doron, 2012, Monk et al., 2006, Vogelpoel and Jarrold, 2014). Furthermore, loss of skills such as driving skills have also been identified (McNamara et al., 2013). However, this is discussed predominantly in the literature about skill development, promoting confidence (Elford et al., 2005, Zander et al., 2013, Tung et al., 2013). Technology's influence in boosting confidence are reported (Cattan et al., 2011, De and Lewin, 2008, Waara and Risser, 2013, Skymne et al., 2012). Connections to older people are strong, for those living with identifiable frailty is variable. What comes over strongly is the impact of an individual losing their confidence resulting in additional healthcare staff contact time and resources to

meet a deficit between a person's loss and their actual or perceived need. This loss of confidence is also a term prominent within the falls literature and is found alongside loss of independence. It is connected to fear of falling and loss of balance confidence (Büla et al., 2011, Gillespie et al., 2013, Yardley and Nyman, 2007). Such psychological and social consequences of a fall are seen as the start of a vicious cycle that leads to reduced activity, physical functioning and further increased risk of falling (Landers et al., 2011). It is recognized that periods spent on the floor, when the person is unable to get up following a fall or waiting for help, are particularly undermining to an individual's confidence (Spinks and Wasiak, 2009). Yardley and Smith called for a better understanding of falling-related beliefs (Yardley and Nyman, 2007), but to date, this remains an area that is largely unexplored despite the impact on older people being significant (Royal College of Physicians, 2008). Psychological and mental well-being aspects of confidence are reflected in other academic work, often connected to studies of falls (Hull et al., 2013, Menzies and Hanger, 2011, Parker, 2000, DalMonte et al., 2003, Nyman, 2011). These articulate connections to a concept of confidence, that is either un-explored or used interchangeably with the established concept of self-efficacy (Bandura, 1994). For example: anxiety and depression relating to balance confidence (Hull et al., 2013) or perceived behavior control being referred to as confidence, when looking at psychosocial factors that could be developed to support older peoples participation in physical activity programmes (Nyman, 2011).

Finally, it cannot be over emphasized that the preliminary searches that informed the systematic review's protocol development, (Underwood et al., 2015) found no narrative to inform the meaning of confidence from the perspective of an older person living with frailty. The nature of the research

identified that the term confidence is referenced more often in quantitative literature, relating to assessment of falls confidence for example, than it is in qualitatively grounded research. It therefore appears that confidence, as a term that is commonly used in clinical practice, has minimal evidenced understanding. The need to understand an individual's belief in their physical and mental abilities when living with frailty becomes important when starting to transfer knowledge from the evidence based literature into practice. It helps if we have clues on how to interpret what confidence really means to an individual and what specifically can be done by healthcare teams and communities to maintain and grow this confidence, especially as we see significant growth in the number of older people living with frailty and dependency across the world.

This meta-synthesis set out to explore the experiences of older people's reference to confidence from interpretive studies. The intention was to produce a valuable systematic review to better understand the meaning of confidence to an older person living with frailty. To ensure the widest scope in capturing qualitative studies describing the meaning of confidence a lower age limit of 60 years or greater was deployed in the search criteria. This meta-synthesis is timely given the growing numbers of the oldest old world-wide. This review is required to inform evidence-based guidance, which can be used to develop clinical practice interventions with older people who have lost confidence, or for those whom it is recognized that the maintenance of their confidence, is crucial to their well-being and healthy living. The objectives, inclusion criteria and methods of analysis for this review were specified in advance and documented

in a protocol (Underwood et al., 2015). This systematic review complies with the recommendations for reporting of systematic reviews detailed in the PRISMA guidelines (Moher et al., 2009).

Review objective and question

The objective of this review was to explore, from the older person's perspective, the meaning of confidence through synthesis of the qualitative evidence relevant to older people living with frailty with a hope to inform healthcare research and practice, service delivery and policy.

The review question was: What is the meaning of the term confidence from the perspective of older people living with frailty?

Inclusion criteria

Types of participants

The review considered studies that included frail adults aged 60 years and over who were currently receiving or had experienced acute hospital and or post-acute care in the last 12 months.

Frailty was recognized using either a pheno-type model (bio-medical criteria such as weight loss or timed walking) or the cumulative effect model (recognized in the aging population as a mental and/or physical health vulnerability and its particular sensitivity to minor stressors, such as an acute infection) (Clegg et al., 2013).

Types of phenomena of interest

This review sought to understand the concept of confidence and how this impacts on the physical health and mental well-being of older people living with frailty.

Context

The review concentrated on studies that presented or reported the older person's descriptions, understandings and meanings of confidence, as it impacts on their health and well-being as they live with their frailty and any connection to recently experienced acute hospital and or post-acute healthcare services.

A PICo (Lockwood et al., 2015) as developed to organize this inclusion criteria information (Table 1).

Table 1: The Systematic Review's PICo. (Lockwood et al., 2015)

PICo	
Population	Older people living with frailty – aged 60 years and older and have recently experienced acute hospital and or post-acute care services.
Phenomena of Interest	The concept of confidence and how this impacts on their physical health and mental well-being
Context	Studies that describe and explore the older person's descriptions, understandings and meanings of confidence and its impact on their health and well-being as they live with their frailty

Types of studies

This review considered studies that focused on qualitative data including, but not limited to, designs such as phenomenology, grounded theory, ethnography, action research and feminist research. Methods of data collection such as interviews and focus group discussions were considered. Mixed method studies were included if the qualitative findings were presented separately within the publication.

Search strategy

The search strategy aimed to find published and grey literature studies. Joanna Briggs Institute's three-step search strategy was utilized in this review (The Joanna Briggs Institute, 2015a). An initial limited search of MEDLINE (OVID) and CINAHL was undertaken using the key words: confidence; (excluding "confidence interval(s)"); old(er) people; frailty. Analysis of the text words contained in the search results' titles, abstracts, and index terms informed the second search. The second search strategy (conducted July and August 2015) used all extracted keywords and index terms and applied them across all identified databases. Thirdly, the reference list of all identified reports and articles were searched for additional studies. A specialist healthcare librarian (RG) implemented the search strategy (Appendix 1, Appendix I illustrates a sample of the database searches). Structured search strategies were constructed, using search terms appropriate for each database, for example the standardized database subject headings MeSH were used in MEDLINE and Emtree in EMBASE. Other standardized headings (controlled vocabulary) were used across the other databases.

Databases included in the search:

AMED; British Nursing Index (BNI); CINAHL; Cochrane Database of Systematic Reviews; EMBASE; JBI Database of Systematic Reviews and Implementation Reports; MEDLINE (OVID); PROSPERO; PsycINFO; SocINDEX.

Databases and web platforms searched for sources of grey literature included:

Dissertation Abstracts International (DAIWorldCat); Google; Google Scholar; Networked Digital Library of Theses and Dissertations (NDLTD); OAlster; OpenGrey; ProQuest Dissertations & Theses Database (PQDTOpen); SIGLE; Social Care Online.

Limitations of the scope of searching

Only studies published in English were considered for inclusion in this review, limited by the review groups language skills, time and resources. Studies published from 1994 to 2015 were considered for inclusion, reflecting the period of recent literature growth in the concept of frailty related studies mentioned above. Finding the voices of older people quoted in studies where title, abstract and subject headings terms are reviewed in the second stage review may have missed data relevant to this systematic review. Comment on this is presented in the results section.

Assessment of methodological quality

Studies selected for retrieval were assessed by two independent reviewers (FU and LB) for methodological strength prior to inclusion in the review using the standardized critical appraisal instrument from the Joanna Briggs Institute Qualitative Assessment and Review Instrument (JBI-QARI) (Appendix 1,

Appendix II), after which the reviewers met to discuss the results of the appraisal. Any disagreements between the reviewers were discussed and resolved. There was no need to refer to the third reviewer (BK).

Data extraction

Data were extracted from studies included in the review using the standardized data extraction tool from JBI-QARI (Appendix 1, Appendix III) by the first two reviewers independently. The data extracted included specific details about the phenomena of interest, populations, context, study methods and outcomes of significance to the review question and specific objectives. Reviewers independently inputted data into the online JBI-QARI, results were then verified by the first reviewer. Where discrepancies existed, a discussion was undertaken to seek consensus. The opportunity to contact authors of primary studies for any missing information or to clarify unclear data was available, but not required. In addition, the third reviewer's opinion was sought to qualify the final decisions.

Reviewers (FU and LB) read each paper several times to gain a comprehensive understanding of the key findings and to set them in context. One reviewer (FU) then extracted the findings from included studies. Where possible, each extracted finding was supported by a verbatim quote from a research participant to illustrate its meaning. Where this was not possible, the study author's narrative was extracted. All findings were assigned a level of credibility (unequivocal, credible and unsupported) in line with JBI guidelines (The Joanna Briggs Institute, 2015b). Levels were assigned depending on the extent to which supporting quotes, detail and relevant context were available and lent weight to the finding's credibility. Both reviewers evaluated the extracted

findings and the assigned levels of credibility and reached agreement that they were appropriate for each paper.

Data synthesis

Qualitative research findings were pooled using the JBI-QARI online platform (The Joanna Briggs Institute, 2015a). This involved the aggregation of all unequivocal graded findings from the final four studies included in the synthesis. One reviewer (FU) led the meta-synthesis to generate a set of statements that represented the aggregation, through assembling the findings based on similarity in meaning (explored in the results section below). Review and re-examination of the original studies, alongside prospective disclosure with co-reviewers (LB and BK) built consensus on interpretation. In the same process these categories were then subjected to meta-synthesis in order to produce a single synthesized finding.

Results

The first phase of the search of MEDLINE (OVID) and CINAHL databases was undertaken using the key words: confidence; (excluding “confidence interval(s)”; old(er) people; frailty. This elicited 57 and 31 studies respectively that met the PICO (Table 1). After removal of duplicates, a final 63 studies underwent a review of title, abstract and subject heading terms. Seven studies cited ‘confidence’ in their abstract, directly attributable to an expressed older person’s viewpoint (Skymne et al., 2012, McDougall and Balyer, 1998, Barnes and Bennett, 1998, Claassens et al., 2014, Sandberg et al., 2014, Peel et al., 2000). Seven additional studies were assessed to have a high probability of

documenting an older person's voice expressing a meaningful description of confidence as they deployed methodological approaches where quotes of research participants would be expected to be expressed (Li, 2005, Kuehner and Buerger, 2005, Parry et al., 2014, Donnelly and MacEntee, 2012, Peduzzi et al., 2007, Kressig et al., 2001, Graham et al., 2014). The subject heading terms of these 14 studies had their term relationships assessed to conclude the final search strategies to be used in the comprehensive second phase search strategy.

Following the second phase comprehensive literature search of databases and web platforms, 11,395 records were identified (Figure 6).

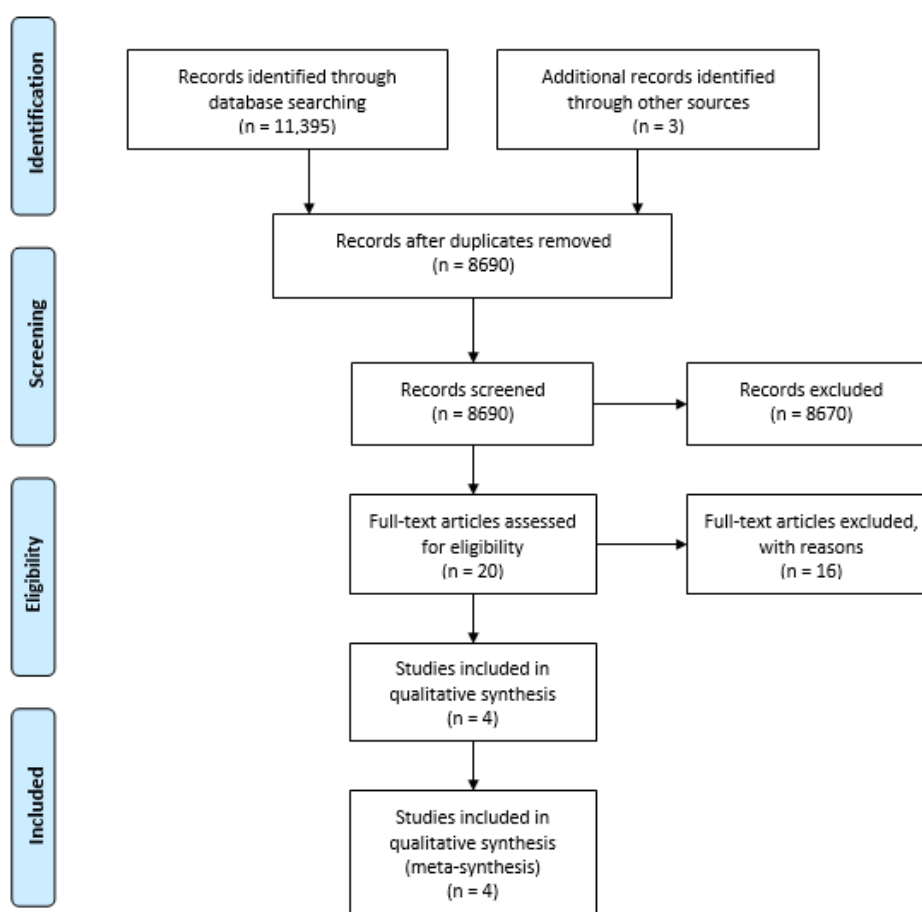


Figure 6: Flow chart of the comprehensive search and study selection process.

An additional article referenced in the systematic review's protocol (Underwood et al., 2015) had not been identified in any of the detailed literature reviews - Nicholson et al. (2012b) was included alongside a further study by the same authors (Nicholson et al., 2012a). A third article was included, found by the author (FU) reviewing research papers relating to his earlier exploration of what confidence may mean – Wallin et al. (2007). In total, a final 11,398 studies were included. After removing duplicates, 8,960 records had their title, abstract and subject headings reviewed to identify qualitative research studies that met the PICO criteria (Lockwood et al., 2015). This evaluation phase excluded a further 8,670 records. Twenty studies were found eligible for full-text article inclusion in the review (Appendix 1, Appendix IV).

The third phase of the search criteria required the reference lists of all identified articles to be searched for any additional studies for inclusion at this stage. Guided by comprehensive reading of the studies, this elicited no further records to be included.

All 20 studies underwent critical appraisal for methodological quality using the Joanna Briggs Institute's Critical Appraisal Checklist for Interpretive Research (Appendix 1, Appendix IV) by the two reviewers. All reviewers were satisfied with the outcome of the critical appraisal stage. At this point 16 studies were excluded. The overarching reason for the 16 studies being rejected at the critical appraisal stage was not necessarily due to research rigor but because no quoted voices of older people were found. The studies mostly contained narrative voices talking of confidence i.e. third-person opinion and researcher interpretation of the participants' experiences. Because none contained

documented voices of the older people talking explicitly of their confidence at this stage of the review, they were rejected as they would not contribute to the main aim of the review. Appendix 1, Appendix V sets out individual rational for study exclusion. This becomes an emerging significant and a limiting factor of this systematic review: as the fewer studies appear to hold the voices of older people talking directly of their confidence the quieter this review can resonate. Four studies were finally included in the qualitative synthesis stage (Tung et al., 2013, Wallin et al., 2007, Resnick, 2002, Beesley et al., 2011).

Description of included studies

Data extraction details of the four included studies are set out in Table 2. One hundred and thirty participants were included across the four included studies (range 11 to 77).

Table 2: Included studies in the systematic review.

Beesley K, White JH, Alston MK, Sweetapple AL, Pollack M. Art after stroke: The qualitative experience of community dwelling stroke survivors in a group art programme. Disabil Rehabil. 2011; 33(23-24): 2346-55.	
Methodology:	Qualitative - Grounded Theory
Method:	Individual interviews and focus groups
Phenomena of interest:	Exploration of the possible health and well-being benefits of a community arts health program for stroke survivors.
Setting:	Community arts health program
Geographical:	Newcastle, New South Wales, Australia
Cultural:	Community dwelling stroke survivors
Participants:	Eleven individual interviews. Nine participants additionally took part in two separate focus groups. All stroke survivors recruited through a stroke service mailing list. Age range 42-81 years.
Data Analysis:	Constant comparison method
<i>continued</i>	

Author's Conclusions:	Despite the difficulty assessing participants level of frailty, three participants (aged 72, 53 and 58) describe low confidence levels following stroke. Although the voice of one participant directly quoted (aged 53) is outside the PICO age range of 60 years it seems appropriate to include as their frailty in this cohort of stroke survivors can be recognized. The authors make connections between confidence and several other factors e.g. self-esteem, self-efficacy and quality of life. Time since stroke for these participants ranges from 8 months to 7 years, the cohort of participants (n.11) had two more recently hospitalized participants e.g. 12 months and less
Resnick B. Geriatric rehabilitation: The influence of efficacy beliefs and motivation. Rehabil Nurs. 2002; 27(4): 152-61.	
Methodology: Method: Phenomena of interest: Setting: Geographical: Cultural Participants: Data Analysis: Author's Conclusions:	Qualitative - Naturalistic Inquiry Individual semi-structured interviews Factors that influence the efficacy beliefs that motivate older adults in a rehabilitation program. Geriatric rehabilitation unit of an orthopedic hospital. East Coast, USA (no further context mentioned) Older people; post orthopedic surgery rehabilitation Seventy-seven over 65-year-olds. Exclusion if significantly cognitively impaired, anxious or aphasic. 18% of participants were African Americans. 18% were admitted non-electively. Content analysis Difficulty to fully assess frailty of participants in the study (n.77). One participant mentions their confidence in relation to the therapy they were receiving. The study is set in the context of self-efficacy theory.
Tung Y-C, Cooke M, Moyle W. Sources older people draw on to nurture, strengthen and improve self-efficacy in managing home rehabilitation following orthopaedic surgery. J Clin Nurs. 2013; 22(9/10): 1217-26.	
Methodology: Method: Phenomena of interest: Setting: Geographical: Cultural Participants:	Qualitative (described as a 'pragmatic, exploratory' approach) Individual semi-structured interviews Sources older people draw on to improve or maintain self-efficacy during post elective orthopedic surgery rehabilitation. At home Australia (no further context mentioned) Older people; post-orthopedic surgery rehabilitation Fifteen over 65-year-olds admitted to hospital for elective orthopedic surgery (three participants were transferred with fractured neck of femur)

continued

Data Analysis: Author's Conclusions:	Thematic analysis The study offers limited ability to assess the participants level of frailty (n.15). Interviews were conducted 6-23 weeks' post-surgery. The study presents one direct quote from a participant where a new piece of mobility equipment gave her confidence. The author refers to confidence throughout the paper interchanging the concept with that of self-efficacy.
Wallin M, Talvitie U, Cattan M, Karppi S. The meaning older people give to their rehabilitation experience. Ageing Society. 2007; 27: 147-64.	
Methodology: Method: Phenomena of interest: Setting: Geographical: Cultural Participants: Data Analysis: Author's Conclusions:	Qualitative (no philosophical framework mentioned) Individual semi-structured interviews The meaning older adults attribute to their geriatric rehabilitation experience. Inpatient geriatric rehabilitation unit and at home Finland (no further context mentioned) Older people; post-acute rehabilitation Twenty-seven participants over 65-year-olds were interviewed twice and included. Excluded if significantly cognitively impaired. Thematic analysis described Limited ability to assess the participants' level of frailty (study states that recruitment may have been biased towards moderately fit individuals and frail people may have declined). However, two participants (n.27) directly mention confidence in relation to the theme 'sense of confidence with everyday life'.

Overall, elements of the PICO were strong across all four studies. However, one element was consistently weaker – the ability for the reviewers to assess fully the participants' levels of frailty. Beesley et al.'s post-ischemic stroke cohort, a morbidity connected to the frailty condition (British Geriatric Society, 2014), reported experience of role-loss and lifestyle change (Beesley et al., 2011). Tung, et al's study notes that participants were living with limited functional status after orthopedic surgery that impacted on their everyday lives which led to life style changes and restrictions (Tung et al., 2013). Whereas in Resnick's study, frailty was recognized in the reference to coding data – the term fatigue

(interpreted as “being slowed up”) was noted as a problem associated with physical function (Resnick, 2002: 154). Finally, in Wallin et al.’s study they record their sample as being “...aged 65 or more years who were coping at home, but threatened by progressively decreasing functional ability. ... All but one man reported one to four chronic diseases that caused functional limitations. ...functional limitations forced all participants to rely at some level on assistance to live at home. The assistance varied from help with transport to assistance with personal care (Wallin et al., 2007: 149).

The reviewers considered this against the context of two key categories of the Clinical Frailty Scale – Vulnerable and Mildly Frail, two that importantly differentiate between frailty and its pre-frail state:

4 Vulnerable – *While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.*

5 Mildly Frail – *These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework. (Rockwood et al., 2005: 490, Geriatric Medicine Research, 2007-2009)*

The reviewers felt that most research participants would have been placed towards the less-frail end of a frailty continuum, around these two statements. The four studies were included in the review balanced on the conviction that frailty was implicit within each of them. However, this clearly illustrates how difficult the judgments were. There were recognized benefits by the reviewers that their contribution could support the overall aim of the review given the

paucity of literature available. Equally this was recognized as a significant limitation too.

Three of the four studies studied older people in the context of rehabilitation programmes (Tung et al., 2013, Wallin et al., 2007, Resnick, 2002) following acute care and the fourth is described as being in the arts health paradigm, promoting well-being through art therapy (Beesley et al., 2011). Although not a traditionally funded health or social care acute or post-acute care program, it was for their research study and connected to the grounding of the other studies - post-acute care services, therapeutic, restorative and within a rehabilitative paradigm. Two of the studies were undertaken initially within inpatient rehabilitation facilities with follow-up in the community (Tung et al., 2013, Wallin et al., 2007), one undertook interviews within 48 hours of discharge from a rehabilitation facility (Resnick, 2002) and one was undertaken solely in the community (Beesley et al., 2011).

Methodological quality

The results of the critical appraisal, assessing methodological quality, for the four included studies (Tung et al., 2013, Wallin et al., 2007, Resnick, 2002, Beesley et al., 2011) are presented in Table 3. The ten questions relate to the questions in the JBI-QARI critical appraisal checklist (Appendix 1, Appendix III). Considering the limited number of studies identified the reviewers decided not to exclude any study based on methodological quality in order capture the few voices of older people available, the four studies scored to a similar standard (Table 3).

Table 3: Quality appraisal for included studies in the systematic review. (Refer to Appendix 1, Appendix III for details of the ten questions)

Studies	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Total Score
Beesley, et al.	U	Y	Y	Y	Y	N	N	Y	Y	Y	7
Resnick	Y	Y	Y	Y	Y	U	N	Y	Y	Y	8
Tung, et al.	Y	Y	Y	Y	Y	U	N	Y	Y	Y	8
Wallin, et al.	Y	Y	Y	Y	Y	U	N	Y	U	Y	7
%	75	100	100	100	100	0	0	100	75	100	-

Criteria: Y - Yes, N - No, U – Unclear

When judged collectively all scored 0% for Q6 – *There is a statement locating the researcher culturally or theoretically* and Q7 – *The influence of the researcher on the research, and visa-versa, is addressed.*

This illustrates a consistently poor attainment of expectations in reporting high quality research study in relations to these criteria (The Joanna Briggs Institute, 2015b). In critically evaluating research, the impact of the researcher on the study should be explicitly described. Understanding their beliefs and values are important (The Joanna Briggs Institute, 2015b), this goes beyond presuming their study's introduction sets this context. In addition, there is a need for a robust and explicit self-critique by the qualitative researcher. Wallin et al. (2007) and Beesley et al. (2011) mention data triangulation and describe rigorous approaches to limiting researcher bias in the data interpretation phase, as do Tung et al. (2013) and Resnick (2002). However, all four fail to describe methodological considerations related to their research, such as: in research question development; on how adjustment was made for sensory impairment

for an older aged research population; in any consequence occurring during the data collection phase (interviews); or on how their relationships regarding perceived power and their societal position with their research participants were minimized or how this may have impacted on their results.

As for methodological aspects of the studies, two make specific commitments to a theoretical construct: naturalistic/constructivist inquiry (Resnick, 2002) and grounded theory (Beesley et al., 2011). The other two committed to a qualitative methodology against no philosophical framework. Each used individual semi-structured interview methods to collect data, one complemented this with focus group data (Beesley et al., 2011).

In total, only eight direct quotes from older people were found across the four studies. The most important aspect these four studies bring to this systematic review is, until now, the hidden voices this review set out to hear.

Results of the metasynthesis

Twelve findings were extracted from the four included studies (Appendix 1, Appendix VI). The Resnick (2002) study cited 11 themes, presented under two high-level categories. Only these two high-level study categories were used in data aggregation. The first named category was also the first theme – Personal experiences, this encompassed the quoted voice from the older research participant talking of confidence. The other ten themes were classified broadly under the second category – Information that influenced efficacy beliefs. It was agreed by the reviewers that individually these ten themes added nothing more to the overall review's aim. Therefore, this study's second high-level category was dealt with as a single finding in this review.

Of the 12 findings, half were evidence graded as Unequivocal [U]: described as: ‘evidence beyond reasonable doubt that may include findings that are matter of fact, directly reported/observed and not open to challenge’ (The Joanna Briggs Institute, 2015b: 156). This sub-group of six findings all had an attributable research participants’ quote that had a direct contextual inference to the finding. In total, there were eight quotes (Appendix 1, Appendix VI).

Table 4 presents the summary of findings table that include the results of category aggregation.

Table 4: Categories and the synthesized finding from the systematic review.

Finding	Category	Synthesized finding
A sense of confidence with every day life (U)	Belief – An emotional drive to achieve an outcome or a self-belief in oneself to achieve a goal	Vulnerability A fragile state of well-being open to conflicting tension between physical, emotional and social factors that can enhance or erode this state
Benefit of art (U)		
Experience of stroke (U)		
Improving self-efficacy through adaptive strategies and goal setting (U)		
Nurturing self-efficacy through working with others (U)		
Personal expectations (U)		
A sense of confidence with every day life (U)	Independence – A functional or emotional state where confidence can be seen to directly enhance or erode the state	
Improving self-efficacy through adaptive strategies and goal setting (U)		
Nurturing self-efficacy through working with others (U)		
Benefit of art (U)	Social connectedness – The individuals connection (or dis-connection) with a social group in the community i.e. friends and family or to a therapeutic or activity group as a programme participant	
Experience of stroke (U)		
Nurturing self-efficacy through working with others (U)		

Three categories with contextual statements emerged from the process of repeated review of the studies' findings and analysis of the written quotes from research participants: Belief, Independence and Social connectedness. The development and interpretation of these categories was drawn from the studies' findings by describing and revising a contextual definition for each category. This was valuable in affirming the categories were accurate.

These contextual definitions were read back into the studies text until no further amendments could be made. A level of saturation was reached with these descriptions

To give a level of additional validity, Table 5 presents the contextual definition of these categories against a dictionary definition.

Table 5: Categories with contextual and dictionary definitions.

Categories	Contextual definition	Dictionary definition(Cambridge University Press, 2016)
Belief	An emotional drive to achieve an outcome or a self-belief in oneself to achieve a goal.	The feeling of being certain that something exists or is true
Independence	A functional or emotional state where 'confidence' can be seen to directly enhance or erode the state.	The ability to live your life without being helped or influenced other people:
Social connectedness	The individual's connection [or dis-connection] with a social group in the community e.g. friends and family, or to a therapeutic / activity group as a program participant.	Connectedness - The state of being connected and having a close relationship with other things or people:

These three categories were meta-aggregated and a single finding emerged – Vulnerability: a fragile state of well-being that is exposed to the conflicting tensions between physical, emotional and social factors capable of enhancing or eroding this state (Table 4).

In line with the development of aggregated categories, the meta-synthesis drew on the emergent categories and their contextual meaning along with re-examination of the original voices of the older research participants. A fragile state of well-being was heard in the text of Research Participant 1 in the Beesley's study, "...*your confidence has been knocked around a fair bit...*" (Beesley et al., 2011: 2350) and Research Participant 5, "...*[stroke] knocks your confidence for six...*" (Beesley et al., 2011: 2351)

These two direct quotes have a negative preposition of what confidence means. Overall, an enhancing as well as eroding element of the finding came through, more positive factors are mentioned. Talking about practicing getting up from the floor, anticipating a future fall, a research participant in the Wallin et al.'s study states: "...*we tried it, several times, and every day it went better and better. It really helped build up your confidence (to the point that I) can get up.*" (Wallin et al., 2007: 154).

This can clearly be seen to relate back to the categories - independence and belief as it informs the synthesized finding of vulnerability.

The final interplay of these elements is how they are interconnected to a person's physical, psychological and social situation. This is best seen through Jessica's words, a research participant from the Tung et al. (2013) study. Describing her transition back home: "*I had my daughter come and do the work*

for the first week, look after me, stay with me ... she did everything. She was a great help. ... you know that was what I needed to have someone here with me for the first week and then I said you can go home because I was more confident and you didn't need to be here.” (Tung et al., 2013: 1220).

An initial vulnerability, where confidence is low was overcome through physical and practical assistance given by her daughter. A growth of physical and psychological well-being brought about a confidence to no longer ask for such help. The social connectedness finding is obvious.

When exploring additional validity it is useful to consider a comparison of the contextual definition, as illustrated above, against a dictionary definition:

Vulnerability - able to be easily physically, emotionally, or mentally hurt, influenced, or attacked (Cambridge University Press, 2016).

This reflects a negative impact and does not mention any social paradigm. Noticeably from the four studies, two very directly identified wider social associations linked to confidence (Tung et al., 2013, Beesley et al., 2011).

All authors were satisfied with the findings from the final data aggregation, which were then additionally shared with and affirmed by a patient and public involvement group formed to develop this review and other frailty related research ideas. They acknowledge that these aggregated findings come from a limited number of studies. They reported that these data start to tell a story that will resonate with older people and will hopefully support practitioners exploring this concept further both academically and in practice.

Discussion

The aggregated finding of this review is drawn from just four research studies that met the inclusion criteria (Tung et al., 2013, Wallin et al., 2007, Resnick, 2002, Beesley et al., 2011). Therefore, no claims of new knowledge can be made to inform older people, practitioners, researchers, service providers or policy makers as this systematic review set out to do. However, an important question arises from these very limited data - what to do now with the reviews' findings reported here?

The word Vulnerable is found to affirm the meaning of frailty, illustrated in a further definition of the term by Walston and Bandeen-Roche: ... *a nonspecific age-associated vulnerability, reflected in an accumulation of medical, social, and functional deficits*. (Walston and Bandeen-Roche, 2015: 1).

A biopsychosocial (Engel, 1977) connections to health and wellbeing are reflected in the review's three emergent categories from study findings that aggregated the final finding – Vulnerability (Table 4). The category Belief recognizes the emotional / psychological desire to achieve a goal; in the category Independence, confidence's connection to (bio)physical/ functional as well as emotional construct were evident in participants' narratives, these were often referred to as self-efficacy; and finally the category Social connectedness acknowledges how the social domain interplayed on confidence and the other categories.

This review recognizes that the topic of confidence is referred to across a wide range of literature connected to older people, many living with frailty. However, meaning and understanding of confidence remains contextually unexplored in

the literature. Without truly knowing what the concept means, much goes misinterpreted and misunderstood. This opens an opportunity for an integrative research program to answer questions this review highlights, including: missing from the literature is a concept of confidence drawn from older people living with frailty. This concept needs developing as it would allow detailed exploration of the relationship between confidence and frailty. Understanding this, insight into new frailty prevention and intervention strategies would evolve. Furthermore, the question - could a restoration of lost confidence reverse frailty or halt its progress? – presents an area for further academic enquiry, as developing measures of confidence in this frail population could lead to reviewing professionals and service impact on interventional work across frailty pathways of care. Opportunities arise for new and innovative interventional approaches formed from the research and further evaluated. It becomes necessary for older people, practitioners, service providers and policy makers, that research exploring meaning and understanding of confidence is undertaken.

Limitation of the review

As discussed earlier, the review did not find the voices of the frailest older people to find meaning and understanding of the concept of confidence. The synthesized findings of this review are drawn from just four research studies that met the inclusion criteria. Assertions cannot be made that an understanding of the concept confidence has been reached. The reviews data offers limited insight into the concept of confidence as described by the cohort of older people living with frailty. Identifying frailty amongst research participants was more difficult to determine than expected, even with very clear definitions. The healthcare setting for these voices all came from a rehabilitative (post-acute),

not from the acute care centered context. Only studies in English were reviewed and these were from developed countries. However, despite this, an important starting point has been generated from this literature and one that has some synergy with interest of academics and healthcare practitioners today.

Conclusions

This systematic review set out to explore, from the older person's perspective, the meaning of confidence through synthesis of the qualitative evidence relevant to those living with frailty. It had ambition to inform healthcare practices, future research, service delivery and policy. This comprehensive review unearthed a true unknown – the literature reviewed held no voices from the frailest older population to give meaning to confidence in relation to living with frailty. A very small subgroup of research participants hinted to some understanding of what confidence means to them. They described confidence in relation to an aggregated finding of Vulnerability, interdependent on their physical, psychological and social status. There remain unanswered questions which should be of interest to professionals, academics, providers and policy makers.

Recommendations

Using the Joanna Briggs Institute guidance for recommendation development (The Joanna Briggs Institute, 2014) implications for practice and research have

been identified and recommendations made. Grade A recommendations are strong and Grade B are weaker recommendations.

Implications for practice

Voices of older people living with established frailty were not found and as a result there is insufficient evidence to offer an understanding of the meaning of confidence. Therefore, practitioners should consider how they are identifying frailty in practice and how they capture and report older people describing their confidence in practice and its personal impact on them. Specific recommendations are listed in Table 6.

Table 6: Recommendations for practice.

Recommendation	Grade
1. Practitioners in acute and post-acute services should consider how they are identifying and responding to frailty in practice, based on the growing evidence available.	B
2. Practitioners should review and evaluate their response to the needs of older people living with frailty who identify confidence as a factor in their care and recovery from an acute event.	B

Implications for research

The systematic review convincingly calls for more research into understanding the meaning of confidence from the frailest in our communities. Considering the review's PICO (Table 1) the following research questions arise:

- How is confidence recognized and understood in acute hospital and post-acute care services for older people living with frailty?
- What are older peoples experience of these services on how they understand and respond to their confidence?
- What are the implications for practice and service development based on older peoples' experiences of how confidence is understood and responded to in acute hospital and post-acute care services?
- What is this concept of confidence? – construct the concept of confidence for this frail population.
- How does the concept of confidence connect to and influence frailty experienced by older people with respect to their physical health and mental well-being?
- Can a concept of confidence be developed that translates to developing countries, who equally face significant population growth of the oldest old in the coming decades, as it will in developed countries.

It is therefore timely and appropriate to pursue a program of research to explore, develop and evaluate the concept of confidence in this vulnerable population. These research questions have been transposed to research recommendations in Table 7.

Table 7: Recommendations for research.

Recommendation	Grade
<p>It is timely and appropriate to pursue a program of research to explore the meaning and understanding of confidence and how clinical practice interventions can enhance outcomes for older people living with frailty, particularly:</p> <ol style="list-style-type: none"> 1. The discovery and development of a concept of confidence relevant to older people living with frailty. 2. The development and evaluation of interventions that draw on the concept of confidence and its impact on frailty. 3. The evaluation of confidence enhancing interventions and their impact on the physical health and mental well-being of older people living with frailty. 4. The development and implementation of international standards on how confidence can benefit health outcomes for older people living with frailty. 	<p>A</p> <p>A</p> <p>A</p> <p>A</p>

CHAPTER 4:

CONFIDENCE RELATED TO OLDER PEOPLE

LIVING WITH FRAILTY: A CONCEPT ANALYSIS

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Published manuscript contribution statement

Based on the International Committee of Medical Journal Editors (2018) recommendations:

Underwood, F. 90%

Conception; design of the concept analysis; acquisition, analysis and interpretation of data; drafting the work and revising it critically for important intellectual content; final approval of the version to be published.

Latour, J.M. 5%

Revising it critically for important intellectual content and approval of the version to be published.

Kent, B. 5%

Revising it critically for important intellectual content and approval of the version to be published.

Introduction

This chapter presents a green final manuscript of a published paper that fulfills the second stage of the study (Figure 7). The Appendix for this manuscript is available in Appendix 2:

		Stages	Study Description	Methodology		
Doctoral Study		Systematic review	Meta-aggregation of contemporary qualitative evidence	JB1 Systematic Review	Knowledge to Action Framework	Knowledge Creation
		Primary concept development	Concept development from contemporary qualitative literature	Walker and Avant method		
		Phenomenological enquiry	Interpretive phenomenology (participant study)	van Manen's methodological structure for human science research		
		Study's findings review	Final concept production	Method Triangulation		

Figure 7: Illustration of the four-stage study design highlighting the study's second stage, the primary concept analysis.

A concept analysis of confidence related to older people living with frailty

Abstract

Aim:

To describe and define a concept of confidence in the context of older people living with frailty, which is important to the world-wide healthy-ageing agenda preventing decline in independence and well-being.

Design:

Concept analysis informed by Walker and Avant's eight stage approach.

Methods:

Electronic databases (Medline, CINAHL and PsychINFO) from 1994 to 2018 were searched. Published studies exploring confidence and excerpts of papers referencing older people, frailty and confidence informed the concept analysis. Extracted attributes informed model case and additional case development. Appraisal of antecedents, consequences and empirical referents informed the final concept's construction.

Results:

Three overall defining attributes of confidence were identified in this concept analysis; physical, psychological and social. A central feature is personal control, influenced by existing internal and external factor. These control factors can be enabling factors (positive factors) or dis-enabling factors (negative

factors), affecting the frail older persons overall physical health and mental well-being.

Keywords

Older People, Concept Analysis, Aged Care, Elders

Introduction

The Cambridge Dictionary defines confidence as *“the quality of being certain in your abilities, or having trust in people, plans or the future”* (Confidence, 2019). Within healthcare literature, loss of confidence is often allied to an aging and older population living with frailty. The World Health Organization has predicted that the global population of those aged 65 or older will triple to nearly 1.5 billion by 2050, with the greatest consequences of this increase being seen in developing countries (World Health Organization, 2011). Many of these older people will also experience frailty, which is defined as *“a clinically recognizable state of increased vulnerability resulting from aging-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with everyday or acute stressors is comprised”* (Xue, 2011: 1). For over 20 years, the idea of frailty has appeared in our healthcare literature (Clegg et al., 2013). Within this, the word confidence is noted frequently in relation to the impact of deficits, impairments and loss. However, confidence is rarely presented from the direct perspective of the older person. It is most commonly tendered via the researcher’s interpretation, often prefixed with self- for example, self-confidence is a component of Maslow’s Esteem stage in the Hierarchy of Need (Maslow, 1943). Across the body of frailty studies, the descriptions of confidence and the context of its use are ambiguous, unclear

and do not allow comparison to be made with each other. Confidence lacks acknowledgement because true conceptual bearing seems not to exist. This is despite the referenced impact, both physically and mentally, throughout these studies. Examples of these range from falls interventions trials looking at balance and strength training; evaluation of frailty in home assessments; the use of technology; through to cognitive behaviour therapy (Doughty et al., 2000, Henderson et al., 1998, Jancewicz, 2001, Kutner et al., 1997, Lelard and Ahmaidi, 2015, Oliver, 2007, Parry et al., 2016, Parry et al., 2014).

Rahman (2019) recently presented contemporary frailty themes facing practitioners in health and social care settings and asks practitioners to be alert to the negative implications associated with the word frailty. He promotes the frailty fulcrum (Moody, 2016), a multidimensional model of the nature of frailty. Elements of this model include: social and physical environments; psychological status, which comprises specific conditions, such as anxiety, or more general feelings like confidence, fear or motivation; as well as long-term and acute conditions. Confidence has a significant impact on the life experiences of older people and is often noted in relation to loss or lack of confidence, which affects constructs such as vulnerability and resilience, both of which impact on a person's health and well-being. Frailty challenges the ability to balance these two concepts. Rahman (2019) promotes the significance of intrinsic capacity or assets connected to resilience models in tipping the balance in favour of a positive health state. These assets contribute to a multi-dimensional health status that encompasses physical functional, psychological and social health, each of which are strongly connected to the healthy-aging agenda of public

health (World Health Organization, 2017). Thus, it is within this context of frailty that the concept of confidence needs to be better understood.

Background

Etymology: the origin of the word

Confidence, according to The Online Etymology Dictionary (Harper, 2001-2017) is first identified in the early fifteenth century, coming from Middle French *confidence* or directly from Latin *confidentia* to mean – ‘firmly trusting, bold’. Interestingly connected to the word *diffidence*. This, from the Latin *diffidentia* meaning ‘mistrust, distrust and want of confidence’ and *diffidere* to mean ‘to mistrust or lack confidence’. A seventeenth century sense of the word *diffidence* recognises it to mean ‘distrusting oneself’, but this is rarely used or heard in contemporary English language today. However, it is in both these words, that the root *fidere*, meaning ‘to trust’, may start to provide insight to its contextual meaning today (Harper, 2001-2017). Confidence is most commonly used as a noun - describing people, place and things and much less commonly expressed as an attributing adjective – confident.

A practical need to understand the concept of confidence

Understanding the true notion of confidence in the context of living with frailty is important to older people, practitioners, service providers, academics and policy makers. This is because loss of confidence has life changing consequences, which can lead to increasing frailty (Nicholson et al., 2012a). Given the worldwide increases predicted in the number of older people and the impact on resources needed to manage frailty, a better understanding of confidence may help develop interventions to support older people to live healthier and more independent lives, and reduce dependency on statutory services. However,

there is minimal evidence capturing the meaning of confidence from the perspective of older people to inform and evaluate effective interventions (Underwood et al., 2017). A recent metasynthesis reported the voices of older people talking about confidence and concluded that confidence reflects a sense of vulnerability. This is: *a fragile state of well-being that is exposed to the conflicting tensions between physical, emotional and social factors capable of enhancing or eroding this state* (Underwood et al., 2017: 1326). The authors concluded with a call for a concept analysis of confidence to progress practice developments and further research. This paper responds to that call.

Two confidence connected constructs that conflict with conceptual development

When considering the contemporary healthcare literature surrounding confidence in older people living with frailty, two substantial bodies of work exist that connect, but also conflict, with any search for conceptual clarity and certainty. The two associations are with: self-efficacy (Bandura, 1994) and the work around balance confidence (Powell and Myers, 1995, Tinetti et al., 1990). Bandura describes perceived self-efficacy as being: *“...concerned with people's beliefs in their capabilities to exercise control over their own functioning and over events that affect their lives. Beliefs in personal efficacy affect life choices, level of motivation, quality of functioning, resilience to adversity and vulnerability to stress and depression”* (Bandura, 1994: 13). Researchers frequently use Bandura's self-efficacy construct interchangeably with the word confidence to the point that many may be interpreting it to mean confidence. Bandura has written about his own view on confidence: *“It should be noted that the construct*

of self-efficacy differs from the colloquial term 'confidence'. Confidence is a nondescript term that refers to strength of belief but does not necessarily specify what that certainty is about. ...Confidence is a catchword rather than a construct embedded in a theoretical system,..." (Bandura, 1997: 382). Here, Bandura clearly argues for a fundamental separation between the two terms.

The second substantial body of work focuses on the development and deployment of a balance confidence scale. Fear of falls is a recognised phenomenon, as is its connection to confidence (Legters, 2002). The Activities-specific Balance Confidence (ABC) scale (Powell and Myers, 1995) and the Falls Efficacy Scale (FES) (Tinetti et al., 1990) were developed to demonstrate interventional impact of studies exploring falls. Both recognised the psychological harm of the fear of falling. Regrettably the FES was created with confidence connections to Bandura's self-efficacy construct, as it was designed to assess perceived efficacy (Tinetti et al., 1990: 239). This critique is not dismissive of these bodies of work, as value is added to academic knowledge through their existence. However, these authors, for clarity of concept construction, acknowledge their presence but cautiously put them to one side in creating this contemporary concept of confidence.

Aims and purpose of this concept analysis

By drawing on contemporary healthcare literature, this concept analysis aims to identify antecedents, attributes, consequences, and present a definition of the confidence concept that will add to the understanding of its use in health and social care in particular, the importance to the world-wide healthy-ageing agenda of preventing decline in independence and well-being. Using Walker

and Avant's procedure for concept development, the purpose will be to disseminate the construct to practitioners, service providers, academics and policy makers. By sharing the conceptual meaning of confidence for older people, research activity exploring its measurement to inform interventional studies will evolve. Longer-term aims will be to use the concept to maintain and grow the physical and mental well-being of older people living with frailty. In turn, such interventions will address the growing social dependency frailty brings to the oldest-old in our societies worldwide.

Design

Walker and Avant's eight stage technique was used to guide this concept analysis (Walker and Avant, 2014). These iterative stages are (i) select a concept, this is set out in the introduction section; (ii) determine the aims or purpose of analysis, of which is set out in section 1.4 [aims and purpose above]; (iii) identify all uses of the concept that you can discover, (iv) determine the defining attributes; (v) construct a model case; (vi) construct borderline, related, and contrary cases; (vii) identify antecedents and consequences and; (viii) define empirical referent.

Method

A literature search was undertaken to address stage (iii) of the concept analysis method. Using the search words older* OR elder* AND / OR people OR person*; AND frail*; AND confidence NOT "confidence interval*", the databases

CINAHL, Medline and PsycINFO were searched going back 25 years, as this was when the formative Rockwood et al. (1994) paper was published. This was the first paper to present a concept of frailty. Only English language articles were included. Inclusion criteria echoed the Walker and Avant (2014) call to not limit the search to the word used to formulate a concept. Therefore, inclusion criteria were: older people focused on those aged 60 and older; frailty was interpreted using the clinical frailty scale definition of mildly frail (a score of 5) and over (Rockwood et al., 2005) (sometimes the word frailty used in an article was included to keep the search open); and confidence was sought in the context of direct or associated description in relation to the above two criteria. There were no exclusion criteria, beyond not meeting the inclusion parameters. Analysis followed the outstanding stages (iv) to (viii) of the concept analysis technique (Walker and Avant, 2014). These are detailed in the results section below.

Results

The search recovered fifty-six articles that met the inclusion criteria, after removing duplicates. Following title and abstract review, 21 were considered for full review. The main reason for rejecting 35 articles was that confidence was not directly contingent to older people; rather it was related to either the confidence of healthcare professionals or carers supporting older people. Reviewing referenced materials, 14 additional papers were included for further review, bring the total to 35 articles. These articles were read and re-read, as defining attributes were extracted from them. These are explored in the concept analysis section below. Following identification of all usages of the word

confidence, an iterative analysis of the material collected was undertaken (Walker and Avant, 2014).

Defining attributes, antecedents and consequences to establish a concept

Utilising the findings of a systematic review (Underwood et al., 2017), defining attributes associated with confidence clustered around physical, psychological and social domains, where attributes are defining characteristics to support the concept's construction. The most frequently appearing attributes give the broadest insight into the concept (Walker and Avant, 2014). From the literature analysed, these attributes were:

- **Physical** – falls associated; strength gaining; activity based, mobility reducing, independence growing, poor balance specific; function losing.
- **Psychological and emotional** - mental frailty connected; memory loss related; creating low esteem, embarrassment and being ashamed; anxiety provoking; grounded in psychological wellbeing; stimulating motivation, body-image affecting.
- **Social** – isolating; engagement with others; connected; community focused; family concern related; orientated to classes, groups, and positive involvement. (see Appendix 2, Table 1 in supporting information: studies included, extracted findings and attributes revealed)

Figure 8 illustrates the concept of confidence. The concept of confidence is defined through the three dynamic domains of confidence: physical, psychological and social. Each individual domain rises and falls in response to the emphasis the individual places on their confidence at any one time. The

cross cutting domain of control directly influences the individuals physical health and mental well-being. This figure presents a fundamental feature drawn from the literature, that of the negative (-) and positive (+) aspects associated with each attribute, each of which influence the element of control, which in turn affect the dominance of the three core components.

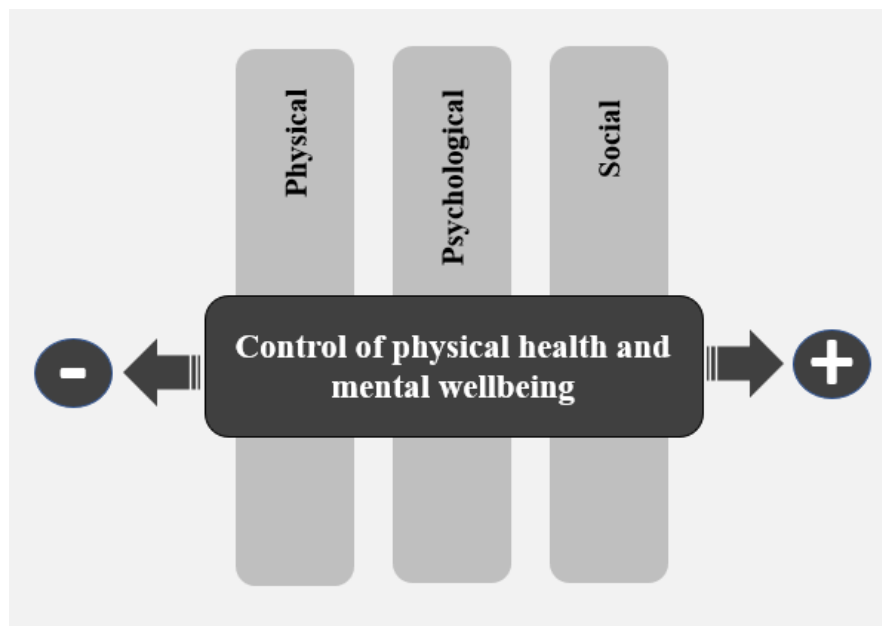


Figure 8: High-level illustration of the concept of confidence in older people living with frailty.

The published research studies focused on interventions that, in part, recognise the impact or consequences of confidence on the older adults. For example Parry et al. (2016) focused on the psychological interventions of cognitive behaviour therapy to reduce the fear of falling. This sits predominantly within the psychological domain of confidence conceptualization. Lelard and Ahmaidi (2015), however, solely review the evidence surrounding physical activity interventions to prevent falls. Both papers do acknowledge the wider multifactorial dimensions of falls, and as such any concept of confidence must

recognize each domain. However, importantly, there may be a greater emphasis on one or more domains. For example, a positive perspective study states: *“Many of the participants reported that their confidence grew, they felt better physically, their mood improved and they had better concentration.”* (McNamara et al., 2013: 34). Whereas, Parry et al. (2014: 1) present negative circumstances associated with confidence *“Many older individuals suffer from a variety of adverse psychosocial difficulties related to falling including fear, anxiety, loss of confidence and subsequent increasing activity avoidance, social isolation and frailty”*. This pattern was repeated across the studies reviewed. Words such as motivation, gaining and growing were connected to a positive inference of confidence, whilst words such as frailty, concern and loss were seen to be negatively associated.

Goal setting and goal attainment were identified in three studies associated with confidence building (Tung et al., 2013, Wallin et al., 2007, Yardley et al., 2006). All were found to be positive, confidence growing, attributes. Furthermore, confidence building attributes were also linked to encouragement and trust (Parry et al., 2016, Sandberg et al., 2014).

Walker and Avant (2014) suggest that attributes should be refined to a point where the fewest number exist whilst they are still able to differentiate the concept. Acknowledging this, the concept of confidence is contextualized against the fluctuating physical, psychological and social domains (the columns connected to a range of attributes). The cross-cutting characteristics of negative or positive inference features ‘control of physical and mental wellbeing’. This control factor, or perceived control, be it explicit or implicit, appeared in several

contemporary studies (Claassens et al., 2014, Parry et al., 2001, Underwood et al., 2015, Wallin et al., 2007, Yardley et al., 2006). It also was referred to indirectly in other studies referencing control associated perspectives within their text, using words such as participation, engagement, independence, self-belief, knowledge, skills and security (Beesley et al., 2011, McDougall and Balyer, 1998, McNamara et al., 2016, Sandberg et al., 2014).

Antecedents and consequences

Walker and Avant suggest antecedents and consequences are often ignored or dealt with lightly in concept construction (Walker and Avant, 2014). As reading and rereading took place to identify defining attributes (stage iv), these antecedents and consequences (stage vii) became clearer and shaped the emerging concept. This process revealed that fear often appeared as a precursor to loss of confidence (Kutner et al., 1997, Lelard and Ahmaidi, 2015, McDougall, 2000, Tavakolan et al., 2011, Tung et al., 2013), for example *“In the frailest older individuals, fear of falling is a pre-dominant characteristic, which seems to be the main factor in determining loss of autonomy [...and confidence]”* (Lelard and Ahmaidi, 2015: 365). Another antecedent was trust (Sandberg et al., 2014, Skymne et al., 2012). However, fear also had a presence as a consequence, stimulating anxiety and subsequent confidence loss (Oliver, 2007, Parry et al., 2016) for example, *“...fear, often but not always occasioned by a fall, is maintained by avoidance of activity, leading to loss of confidence, physical weakening and more fear of falling”* (Parry et al., 2016: 7). Other consequences of confidence include the creation of personal barriers, for example stopping a social activity, and creating mental challenges to overcome, such as setting personal achievement goal (Beesley et al., 2011, Claassens et

al., 2014, Doughty et al., 2000, Lelard and Ahmaidi, 2015, McDougall, 2000, Peduzzi et al., 2007, Resnick, 2002, Skymne et al., 2012, Tung et al., 2013). All these contributed to a very complex analysis. Walker and Avant (2014) recognize this and suggest creating illustrations by using a range of examples to support a more definitive definition of the concept (stages v and vi). This takes the form of a presentation of a model case alongside other cases (Table 8).

The Model case for confidence

An example of the use of the concept confidence was developed (Table 8).

Table 8: Model, borderline, related and contrary cases of confidence.

	Model case	Borderline case	Related case	Contrary case
Confidence	Mrs. P. is 87 years old and lives with multiple morbidities. Six weeks ago Mrs. P. had a fall. She was frightened of having a further fall and this quickly affected her psychological well-being, she became quite anxious, not wanting to go out the house.	Mr. Q. he is 89 years old. He lives with multiple morbidities and like Mrs. P fell six weeks ago. This fall shook him. He was assessed and received some assistive devices to maintain his independence. For a short period of time he received in-home support to help him practice strength and	Mrs. R.is 92 years old she too lives with multiple morbidities but despite never falling, she is fearful of falling and this does have the potential for adverse psycho-social effects. It can impair her self-efficacy – <i>“the self-perception of ability to</i>	Mr. S.is 65, he has just retired and describes his physical and mental health as good. He takes tablets to control hypertension, he monitors this himself and records the results online, he has not seen his General Practitioner in the last five years. Six weeks ago, he went on <i>continued</i>

	<p>She was promptly assessed at home by community healthcare staff who provided assistive devices and gave instruction and coaching on how they can be used to prevent further falls. As trust built in knowledge and use, so her mental well-being and physical health grew. Mrs. P was supported to attend strength and balance exercise classes in her local community centre.</p> <p>She enjoys getting out now to these social activity events in the community and meeting others. She actively takes part in physical strength and balance classes;</p>	<p>balance exercises. He was given information about local exercise groups he could join.</p> <p>Mr. Q. gets out socially to regular community activities and events now. Mr. Q. suffers with mild memory problems and sometimes his mood is low. This restricts his social interactions with others, but he benefits physically from the exercise classes.</p>	<p><i>perform within a particular domain of activities resulting in activity avoidance, social isolation and increasing frailty”</i> (Parry et al., 2014: 2). <i>“Beliefs in personal efficacy affect life choices, level of motivation, quality of functioning, resilience to adversity and vulnerability to stress and depression”</i> (Bandura, 1994: 13).</p>	<p>his first cycling holiday abroad, to the mountains of Spain. Mr. S is an active member of a local cycling club, regularly cycling in excess of 100Km a week.</p> <p><i>continued</i></p>
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	she particularly enjoys her Tai Chi class. This benefits her physically, but also her psychological well-being is boosted.			
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For Mrs. P., the concept's antecedent is a fear of falling, following a previous fall see Figure 9, which illustrates the dynamic properties of the concept derived from Mrs P's fears and concerns. Therefore, the physical, psychological and social domains have been adjusted to reflect a dominance in the psychological attribute.

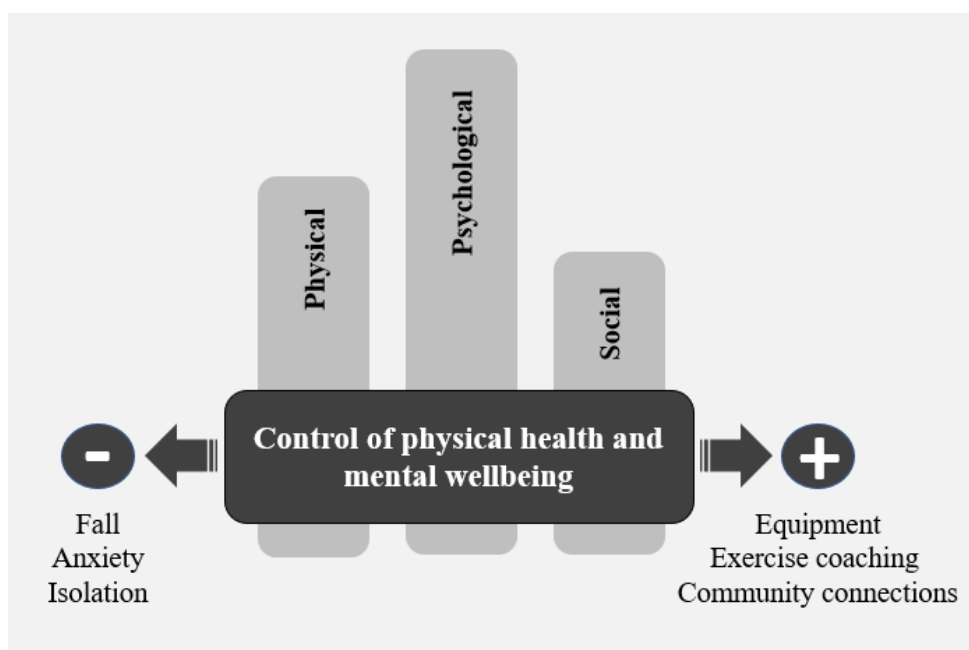


Figure 9: The concept of confidence - illustration of Mrs. P. (Model case).

Furthermore, the negative elements of the attribute are reflected by the physical fall, the associated worry and anxiety and resulting isolation. Following

intervention from the community team (which included equipment provision supported by exercise training, coaching and reconnecting socially) improvements were seen in her physical health and to her mental well-being. These shifted confidence to a positive position. Central to the concept is level of control.

Other cases

Additional cases were created to allow for defining attributes to be clearly associated with the emerging concept of confidence. This gives transparency to the model case through defining what it is not (Walker & Avant, 2014). In Table 8, three alternative cases are presented, headed as Borderline, Related and Contrary. The Borderline case is that of Mr. Q, which contains most, but not all, of the defining attributes of the Model case. This case's difference reflects the studies suggesting an association between confidence, memory perception and low mood. Mr. Q's memory disables and isolates him from the social connection column of the concept seen in Figure 8. Bensadon (2011) writes of memory anxiety and the impact on self-confidence and McDougall and Balyer (1998) explore depression linked to memory confidence. Mood connections were identified in other studies that connect to socially isolating factors (McNamara et al., 2013, Oliver, 2007, Parry et al., 2016). This discrete difference in the Borderline case emphasizes the importance of social connectedness as a key attribute in the Model case and the need to keep all three domains present and balanced. Of course, opportunities for Mr. Q to socialize can be created. However, it highlights how intrinsic factors (e.g. mood and memory problems) can hinder participation, as well as the confidence boosting benefits of social

participation. The Related case of Mrs. R. brings to this concept analysis the construct of self-efficacy (Bandura, 1994). Related cases do not contain all the defining attributes of the Model case but reflect its connection to any concepts surrounding it. These cases are useful for presenting ideas that are similar to the main concept, but differ when closely examined (Walker and Avant, 2014). The two quotes for this case in Table 8 illustrate connections to physical, psychological and social domains of the concept. However, these are from a contradictory view on the foundations of self-efficacy theory. The final case is the Contrary case of Mr. S. This concept of confidence from the perspective of the frail older person is clearly not demonstrated in the description of the healthy and active cyclist. Walker and Avant (2014) present Contrary cases as examples of what the concept 'is not'.

Empirical referents

Stage (viii) of the Walker and Avant (2014) concept analysis technique focuses on the identification and recognition of empirical referents to capture and measure the concept. This is often the final step in analysis and asks: what if the concept was to be measured in the real world? As discussed in the introduction, measures of confidence have been academically explored including the FES and ABC Scales. These are established measures of falls self-efficacy and balance confidence. They may provide an adjunct into the exploration of falls related confidence or the fear of falling. They focus on physical function, acknowledging they are implicit measures to social connectedness (e.g. walk in a crowded mall) and mental well-being. However,

they are not explicit in measuring these latter domains and as such they do not capture all aspects of the concept of confidence. In the absence of measurement tools, Walker and Avant (2014) advocate identifying defining characteristics, or attributes, of the concept to support future instrument development, which can then be used in practice. This concept analysis has generated a wide range of attributes from the literature that could inform such developments. However, it needs to be recognised that, as this is an emerging concept (Morse et al., 1996), further explorations of attributing factors are required to define and develop a robust instrument to measure this concept.

Discussion

The need to explore the concept of confidence as perceived by older people living with frailty is enhanced due to the growth in numbers of the oldest old worldwide, many of whom who will live with frailty. This is further reinforced by the legitimate aim of seeking interventions to reduce the dependency burden on the individual and wider society. Confidence is a concept that, for this population, has not been defined and described until now. Etymological exploration of the word confidence identified the old connected word - diffidence - meaning 'distrusting oneself'. Within the contemporary literature review, this is captured by Parry et al. (2016) as they postulated that activity avoidance (in respect to distrusting oneself) can lead to social isolation and increasing frailty. Skymne et al. (2012) explored how frail older people experience and adapt to assistive devices to support their independence. They analysed confidence in the context of knowledge and experience. For their study participants this meant trusting the experts providing the devices and trusting themselves in

knowing they needed an assistive device to support them. Trust is present in another paper (Sandberg et al., 2014). This qualitative study explores complex case management interventions from the perspectives of older people and their case managers. Trust is reported as being an essential component of the mutual confidence built during such interventions, highlighting its importance in maintaining constructive relationships between patients and caregivers (Sandberg et al., 2014). The dictionary definition of confidence also reflects this element of trust: “...*having trust in people, plans, or the future*” (Confidence, 2019). Indeed, a meta-analysis of trust in healthcare professionals and health outcomes revealed a positive correlation (Birkhäuser et al., 2017), with greater trust being associated with better health outcomes.

Trust and confidence are another concept combination that exist interdependently. Luhmann (2000) draws a useful distinction between confidence and trust, one dependent on perception and attribution. He suggests that if you do not consider alternatives (such as getting in a car and driving, despite a moderate cognitive impairment for example), you are in a situation of confidence. However, if you choose an action in preference to others, despite the possibility of being disappointed by this choice, you define the situation as one of trust. In the case of confidence, you will react to disappointment by external attribution. In the case of trust you will have to consider an internal attribution and eventually regret your trusting choice (Luhmann, 2000: 3). This gives important insight into the wider meaning of confidence and recognises the importance of control. This perceived control relates to the balancing act of asset recognition of older people with advancing age and frailty (Rahman,

2019). The concept of confidence that has emerged from this concept analysis acknowledges an individual's control as an overriding factor connected to the older person's health and well-being. This central element of the concept is influenced by a range of attributes across the physical, psychological and social domains. Crome and Lally (2011) connect frailty to immobility, instability, incontinence, intellectual impairment and iatrogenesis; all of which have a strong evidence base, from a practitioner's perspective. The three domains, of physical, psychological and social connect to an intervention framework familiar to practitioners in older peoples care known as Comprehensive Geriatric Assessment (CGA) (Ellis et al., 2011). Thus, there is now an opportunity for this concept of confidence to contribute to a range of established interventions.

Limitations

This concept analysis is limited by the core search terms used and exclusion of non-English language studies. Although databases used were judged to hold wide bibliographical data sources, some literature may have been missed. Additionally, new literature since the study concluded in 2018 may produce further insight into the concept. It is possible that by using the adjective, confident, in the search and including other language publications, additional attributes may have emerged. Furthermore, this concept analysis clearly articulated a cautious separation from published studies connected to self-efficacy constructs or scales for measuring balance confidence. This too may have affected the outcome of the concept analysis. However, careful consideration was taken to avoid such judgmental bias, by taking guidance from the core texts of Walker and Avant (2014: 175-178).

Conclusion

By using the Walker and Avant (2014) eight-stage process, a concept of confidence experienced by older people living with frailty has been defined and described. Extensive analysis identified a concept constructed of three core domains - physical, psychological and social. Each of these domains could be imagined to be rising and falling in response to the emphasis the individual places on their confidence at any one time. The cross-cutting central domain of control the individual has over the core three domains directly influences their physical, mental and social health and well-being.

Implications

Implications for practice

This concept of confidence provides nurses with a practical framework to facilitate confidence focused conversations. These can inform understanding of confidence experience with older people. As the domain of control overarches the other three conceptual domains, nurses can explore ways to influence feeling of control to improve health and well-being outcomes. Adoption of confidence conversations should be explored within local approaches to Comprehensive Geriatric Assessment with older people living with frailty. Finally, educationalists should help disseminate this new description of confidence to remove ambiguity and enhance understanding when listening for and responding to the word confidence in practice.

Implications for research

As no confidence measurement tools currently exist; there is now an opportunity to develop these to influence practice innovation and evaluate further research.

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Conflict of interest

The authors declare no conflict of interest with respect to the research, authorship and/or publication of this article.

Ethical approval

Not required.

Supplementary data

Appendix 2, Table 1 – Analysis of confidence extracts taken from included studies and attributes extracted to inform the concept of confidence's development

Author Contribution

Study design, FU, JML, BK. Data acquisition, FU. Primary data analysis and interpretation FU. Further analysis and interpretation of data, FU, JML, BK. Manuscript preparation FU. All authors revised the paper for important intellectual content, approved the final version to be published and agreed to be accountable for all aspect of the work.

CHAPTER 5:

UNDERSTANDING THE CONCEPT OF

CONFIDENCE USING PHENOMENOLOGICAL

ENQUIRY: STUDY DESIGN

Introduction

This chapter presents the specific research study design and methodological approach relating to the third study stage, the interpretivist phenomenological enquiry (Figure 10).

	Stages	Study Description	Methodology	
Doctoral Study	Systematic review	Meta-aggregation of contemporary qualitative evidence	JBI Systematic Review	Knowledge to Action Framework Knowledge Creation
	Primary concept development	Concept development from contemporary qualitative literature	Walker and Avant method	
	Phenomenological enquiry	Interpretive phenomenology (participant study)	van Manen's methodological structure for human science research	
	Study's findings review	Final concept production	Method Triangulation	

Figure 10: Illustration of the four-stage study design highlighting the study's phenomenological enquiry stage.

The aim of this substantial stage of the research study was to generate contemporary evidence of the lived experiences of older people living with frailty and those supporting them, to construct conceptual meaning and understanding. This body of work will hold significant weight in the final conceptual analysis of confidence. The study had two objectives:

1. To conduct a phenomenological enquiry to understand the lived experience of the phenomena of confidence and its contextual relationship with frailty, in:

- Older people living with frailty at home, with recent acute hospital or intermediate care experience

and with:

- Carers of such older people who live with frailty
- Healthcare staff caring or supporting such older people living with frailty (exploring practical application of emerging conceptual ideas)

2. To pragmatically synthesise the evidence and interpretive enquiry, using human science phenomenology techniques, to produce a construct of what 'confidence' is in relation to older people living with frailty.

This section is grounded in a methodological human science approach, influenced by the work of Max van Manen, Professor Emeritus of the University of Alberta (van Manen, 1990, van Manen, 2002, van Manen, 2014). The chapter presents first this epistemology, then details the methodological approach to this phenomenological enquiry. The chapter moves on to detail the

practical aspects of the participative study, presenting the study protocol. The chapter concludes by considering trustworthiness within phenomenological research and sets out how this assessment will be performed across this enquiry and the wider body of work this study covers.

Interpretive phenomenology and its human science epistemology

In this search for confidence, with the aim of identifying its meaning and understanding as well as looking at practical implications, the approach by Creswell (2007) was adopted, to take the worldview and be a pragmatic researcher. Pragmatists look at *the 'what' and 'how' to research based on its intended consequences* (Creswell, 2007: 23).

Within the qualitative paradigm, Morse (1994) describes a range of strategies or approaches to answering qualitative research questions. These include qualitative ethology and participant observation for behavioural questions; ethnomethodology and discourse analysis for questions of verbal interaction and dialogue; grounded theory for process questions and theory generation; ethnography for descriptive questions of values, beliefs and practices of cultural groups; and finally, to address questions of meaning and understanding, to elicit the essence of experiences, phenomenology. This latter strategy is grounded in the paradigm of philosophical phenomenology; the study of the fundamental nature of knowledge, reality, and existence of phenomena. Consequently, this was considered to be the most appropriate strategy for this study stage, *aimed at discovering more about the phenomena* of confidence (Morse, 1994: 224).

Reaching the existence of the phenomena, or essence of human nature, this lived-experience is bound in the philosophical and practical complexities of

interpretivist phenomenology. Creswell's (2007) constructivist worldview includes phenomenology method, a paradigm in which one searches for understanding and meaning in the world in which we live. In this approach, research relies on the multiple views of participants, as the complexity of the subject is always socially constructed or interpreted. Creswell (2007) cites the then contemporary work of Moustakas (1994) and van Manen (1990), as does Morse (1994), as proponents with interpretivist methodological underpinnings that can be grasped by more researchers. It is important to not confuse interpretive phenomenology by van Manen (1990) with the Interpretative Phenomenology Analysis method (Smith, 2010, Smith and Eatough, 2006, Smith and Osborn, 2015). Interpretive phenomenology is much more than a method. It has a rich philosophical context that needs to be understood and valued to enable justification in its use as a method of reaching a lived experience. Both Moustakas (1994) and van Manen (1990) recognise this. van Manen, in a later publication, moved the dialogue on from mere oversight of these philosophical foundations, to an agogical approach (van Manen, 2014:19). Agogy means pointing out direction (van Manen, 2014:19). He provides the connection to *phenomenological thinking and research in a manner that shows, in a reflexive mode, what the phenomenological attitude looks like* (van Manen, 2014:19). Applebaum (2007) is critical of van Manen's approach however, suggesting he blurs the important difference between the two major fields of phenomenological study (descriptive and interpretative), thus providing an epistemological inconsistency to discovery. Applebaum's full critique is published in Spanish, so it was not possible to explore this further using the primary source. This criticism, however, of the nature of knowledge

underpinning van Manen's guiding way, his agogical approach, does navigate these two fields and many others in his later publication: *Phenomenology of Practice* (van Manen, 2014). van Manen's openness and accessibility were said to support the modernisation of human science phenomenology as a methodological approach (Dowling, 2007). Understanding these phenomenological foundations are important, as phenomenology requires thoughtful positioning of personal experiences, attitudes and beliefs during the exploration of phenomena.

Human science epistemology

Human experience is the main epistemological basis for qualitative research, but the concept 'lived experience' possess special methodological significance. (van Manen, 2014: 39)

Human Science, as we understand it today, originates from the work of Wilhelm Dilthy (1833-1911), a mid-nineteenth century German philosopher whose Philosophy of Life deviated from the then growth in natural science or the physical sciences, to that of human nature studies (Rickman, 1979). van Manen notes that Dilthy first offered a systematic explanation of lived experience and its relevance to human science:

lived experience is a reflexive or self-given awareness that inheres in the temporality of consciousness of life as we live it ... it is only with thought does it become objective. van Manen (2014: 39)

This reference point influenced philosophical musings for decades to come. The pre-reflective state of actual experience, as it is lived, is the essence of phenomenological enquiry. The impossibility of a pre-reflective state to exist beyond that time just past torments, as thought and reflection crush its existential state. Edmund Husserl (1859-1938), the principal founder of

phenomenology (Beyer, 2016), describes phenomenology as a life-world, a *primal impression of consciousness* (van Manen, 2014: 96), one that is immediately experienced, in a pre-reflective moment. This is in contrast to the more cognitively aware and reflective moments that allow us to conceptualise, categorise or theorise our experiences (Husserl, 1964). van Manen agreed, and articulated phenomenology as offering a *possibility of plausible insights that bring us in more direct contact with the world*, as it is immediately lived and experienced (van Manen, 1990: 9). Described another way, van Manen describes phenomenology as the study of what gives itself ‘as’ lived experience (van Manen, 2017b: 812), the ‘as’ being the infinite number of human experiences, or phenomena, that exist to be explored, described or interpreted, from the mundane to the fantastical. Husserl’s ideas, views and approaches to phenomenology changed throughout his lifetime. However, he will always be linked to the field of transcendental or descriptive phenomenology. Students of Husserl, Heidegger (1889-1976) and later Gadamer (1900-2002), followed different philosophical paths in their studies. These latter philosophers developed the field of hermeneutic or interpretative phenomenology and were central influencers for van Manen, as he secured his own approach and drove forward in recent times to make phenomenology accessible to practitioners. However, van Manen roots his method in this human science approach to phenomenology (van Manen, 1990, van Manen, 2014).

Methodological structure for human science research

van Manen (1990: 31-34) presents a six element, non-linear framework to researching in human science (Table 9). This was adopted for this study's phenomenological enquiry to ensure the best opportunity to produce a faithful interpretation of the phenomena of confidence. Each of these stages are explored further.

Table 9: Methodological structure for human science research.

1. Turning to a phenomenon which seriously interests us and commits us to the world
2. Investigating experience as we live it
3. Reflecting on the essential themes which characterise the phenomenon
4. Describing the phenomenon through the art of writing and rewriting
5. Maintaining a strong and oriented relation to the phenomenon
6. Balancing the research context by considering parts and whole

van Manen (1990: 31-34)

1. Turning to a phenomenon which seriously interests us and commits us to the world

This element of human science sees the phenomenological researcher committing to a *never wavering* focus on a single thought or notion, through the *practice of thoughtfulness*. Here, this researcher *sets out to make sense*

of a certain aspect of human existence (van Manen, 1990: 31) – the notion of confidence. In Chapters 3 and 4, commitment to understand this global phenomenon of interest has been described and begun to be explored.

2. Investigating experience as we live it

This element puts the researcher central to the lived experience. van Manen cites Merleau-Ponty (1962) to explain how the researcher must re-learn *to look at the world by re-awakening the basic experience of the world*. In other words, to reach for the original experience and the *wisdom* it shows *in the midst of the world of lived relations and shared situations* (van Manen, 1990: 31-32).

In part this is achieved through data collection methods, the face-to-face interview process and through data analysis, the approaches adopted to reach the original experience and wisdom it holds. For these, a structured process was agreed to enable this. A reflective research diary was used throughout the study to assess how the researcher was *re-learning* to look at this new world of confidence. In addition, post interview reflective notes aided understanding and experienced impact of each attempt to reach the older persons' lived experience encounters. With regard to the analysis of data, the digitally recorded and transcribed conversations, a structured methodological approach was applied to examine and explore each participant's interview (van Manen, 2014: 319-323).

Table 10 details this approach and Appendix 3 contains a sample of six interviews analysed using this approach.

Table 10: The methodological approach to interview analysis respecting human science.

1. **Individual interview analysis** – this describes the phenomena by reading and writing, rereading and rewriting the experience of confidence from the digital interview recording and transcript. The identification of incidental themes are derived and documented. This is referred to as the holistic reading approach.
2. **Meaning and understanding review** – this analysis section identifies statements and phrases from the interview recording and transcript that illustrate the incidental themes and aspects of lived experience. This is called the selective reading approach.
3. **Guided existential inquiry** – this final analysis section requires a comprehensive rereading of the interview to identify how the lived-experience is revealed, based on van Manen’s existential method: spatiality, corporality, temporality, relationality, and materiality (van Manen, 2014: 302-310). These are described in more detail below. This is the detailed reading approach.

van Manen (2014: 319-323)

3. Reflecting on the essential themes which characterise the phenomenon

van Manen writes that phenomenological research consists of a reflectivity that *brings a nearness to that which tends to be obscure* (van Manen, 1990: 32). To enable this obscure and nebulous concept of confidence to emerge,

it is the researcher's reflective attitude that is at the heart of phenomenological study. There is a compelling balance to strike between the *epoché* and the *reduction* in phenomenology. These are two phenomenological concepts that allow separation from influence and at the same time, allow appearance of the phenomena, through these essential themes as an example. As the philosophy of phenomenology has differing world-views, these affect and direct the researcher's approach to the epoché-reduction (van Manen, 2014). For this study's reflective stance, a heuristic approach was taken with the epoché, influenced by the practical aspects of the eidetic reduction. These both lend themselves to the pragmatic researcher's worldview (Creswell, 2007).

The heuristic epoché

Heuristic refers to a practical problem-solving method, one that may not be perfect, but is rational and logical and supports self-discovery and learning through and by experience. Epoché relates to the research's approach to the suspension of judgement and belief they have, or may have, about the phenomena. It becomes about how they open themselves up to the experience of the phenomena as it is lived. van Manen (2014) notes that this wonder is the phenomena itself. He the writes:

Wonder is the unwilling unwillingness to meet what is utterly strange in what is most familiar. Wonder is stepping back and letting things speak to us, an active-passive receptivity to let the things in the world present themselves on their own terms. (van Manen, 2014: 233)

This is useful in defining an approach to capturing the voices of older people through interviews, and the analysis of these interviews. It shaped the phenomenological mind or reflective attitude required to undertake them and do justice to the stories told. In the discovery of wonder, van Manen states, *you see the unusual in the usual and the extraordinary in the ordinary* (van Manen, 2014: 233). The epoché connects to the researcher's openness to a simple wonder without judgment; in this research, notes were made to record this discovery process and to report openly and transparently about how this happened. For each interview analysed, this researcher wrote an account of how the epoché and reduction were experienced and used (see Chapter 6, Table 17 for an illustration of this in practice).

The eidetic reduction

The overall emergence of understanding is called the reduction. van Manen (2014) describes this eidetic reflective approach as the 'whatness' and writes that this reduction seeks to describe *'what' shows itself in experience or consciousness and 'how' something shows itself...* focusing on what is distinct or unique in a phenomenon (van Manen, 2014: 228-229). This connects back to the pragmatic researcher's worldview (Creswell, 2007). This reductive approach connects to the grasp of *essential insight in testing the meaning of what you search* (van Manen, 2014: 229). Through self-discovery and learning, it allows for different perspectives to be drawn upon to reach the ultimate reduction. The reduction is not an end in itself, it is a means to an end: *to be able to be returned to the world as lived in an enriched and deepened fashion* (van Manen, 2014: 227).

Essential themes

Essential themes emerge through the researcher's reflexive stance on interpreting incidental items and interview analysis. Essential themes need to describe the *experience of meaning* (van Manen, 1990: 87). Their existence, as essential to the phenomena, are tested and justified in the context of the human subject as they have lived it.

Essential themes connect directly and uniquely to the phenomena: they are *the means to get at the notion; they give shape to the shapeless; describe the content of the notion* and a theme is *always a reduction of the notion*. (van Manen, 1990: 88)

4. Describing the phenomenon through the art of writing and rewriting;

To write is to rewrite (van Manen, 1990: 131). The language of human science writing shows how phenomenological knowledge is held and communicated; it is primarily seen as a form of writing. Recognition, that in order to do justice to the lifeworld experience, phenomenological texts must turn into rewritings (van Manen, 1990). He recommends a process of *re-thinking, re-flecting and re-cognizing* (p.131). This allows the sensitive human nature of the phenomena to be creatively explored and exposed – both to the researcher during the process and in the reader of the final work. This describes the art to the (human) science. van Manen draws inspiration from the great philosophers of phenomenology to connect *language and thoughtfulness* to phenomena (van Manen, 2014: 357-391), recognising that the creation of the phenomenological text *is* the object of the research process, the ultimate means to the end of the practice. This approach to

writing is seen in each individual interview analysis and in the description of essential themes.

5. Maintaining a strong and oriented relation to the phenomenon

This methodological structure of human science research requires the researcher to remain strong in their commitment to the topic of enquiry. The academic rigour required is demanding and cannot be underestimated. van Manen warns of being side-tracked or stopping early, before full phenomenological exposure is established; or becoming *enchanted with narcissistic reflections* (van Manen, 1990: 33). This thesis is testament to the continued commitment to unearthing understanding and meaning of confidence.

6. Balancing the research context by considering parts and whole

van Manen (1990: 33-34) reminds the human science researcher not to lose sight of the end of the phenomenological research. The text and narratives that present the findings of the study must remain true to the human science approach of revealing the phenomenological search. They must also remain true to the aim of the study and its wider research question. In this case a meaningful conclusion to explore application of this new knowledge in clinical practice. In this study the different perspectives of carers of older people who have confidence concerns and of the healthcare professionals dealing with these concerns in practice have contributed to these overall findings.

van Manen's writings on the human science approach to phenomenology are said to provide solutions to phenomenological reduction (the personal suspension of knowing the theories, the research, and the practice to focus solely on the essence of the life-world being uncovered) that many researchers search for (Dowling, 2007). This is essential to discover the lived experience of confidence.

The next section of this chapter details the study protocol for the phenomenological enquiry.

Discovering the lived experience of confidence: An interpretive phenomenology study protocol

Objectives

1. To conduct a phenomenological enquiry to understand the lived experience of the phenomena of confidence and its contextual relationship with frailty, in:

- Older people living with frailty at home, with recent acute hospital or intermediate care experience

and with:

- Carers of such older people who live with frailty
- Healthcare staff caring or supporting such older people living with frailty (exploring practical application of emerging conceptual ideas)

2. To pragmatically synthesise the evidence and interpretive enquiry, using human science phenomenology techniques, to produce a construct of what 'confidence' is in relation to older people living with frailty.

Sampling and sample size

Sampling was purposive, aiming to generate the greatest insight and in-depth understanding into the phenomena. It was based on the idea that purposely chosen (targeted) participants, those who will give you the best insight, will best support the aim of the research strategy and method (Braun and Clarke, 2013). Sample size was estimated to be approximately 30 participants. Approximately half of these were intended to be drawn from the patient cohort, in line with the study's aim to develop the concept from the lived-experience of older people living with frailty, aiming for 14-16 older people. 6-8 carers and 6-8 health care professionals were to be included in the study. This sample size fits with established suggestions on sample size for such qualitative research (Creswell, 1998, Guetterman, 2015). Significant to the sample size is the assurance that true meaning of the phenomena is reached. This is achieved by reaching a level of data saturation, described as a *point when additional data fails to generate new information* (Braun and Clarke, 2013: 55). For this study, enquiry of saturation was checked in the post-interview reflection following the first ten interviews with older people and following each interview thereafter. When no new ideas on confidence emerge, suggestion that saturation has been reached were confirmed by the research supervisors.

Participants and participant selection

Three participant groups were identified to inform the study's aim: older people living with frailty who have recently experienced acute hospital or intermediate care; carers of frail older people and healthcare staff providing care and treatment to these older people. The focus on post-acute care was chosen because the presence of confidence in the mind and thought of older people was likely to be heightened. Post-acute care can provide opportunity to recall acute stressors and consider their consequences (connected to frailty's definition (Xue, 2011)), such as a fall, or following a delirium, as recovery and discharge planning are being addressed. Patient and carer cohorts were recruited by senior registered practitioners from the care of the older peoples' wards over two hospital sites. Referrals were triggered by these staff responding to the use of the trigger word 'confidence' being used in conversations with patient and carer cohorts. Confidence would be expressed in relation to their personal lived experience. The trigger word allowed senior practitioners to screen the individual against the inclusion and exclusion criteria (Table 11). Suitable participants were given a participant information sheet and verbal consent was taken to be referred into the study. The Chief Investigator (the researcher) visited the inpatient area to meet the participant and negotiate a suitable time to discuss the study further and arrange the best place and time for an interview.

The healthcare professionals' cohort was approached by the researcher, purposefully targeting those who referred older people and carers into the study who met the inclusion criteria (Table 11). Healthcare professional participants were drawn from any registered professional staff group.

Table 11: Phenomenological study inclusion and exclusion criteria.

Cohort	Inclusion Criteria	Exclusion Criteria
Older People Cohort	<ul style="list-style-type: none"> • 65 years of age and older • Have frailty as defined by the Clinical Frailty Score of 5 (mild frailty) to 8 (severe frailty) (Rockwood et al., 2005, Geriatric Medicine Research, 2007-2009) • Could have a <i>mild</i> cognitive impairment – score of 7 or greater on Abbreviated Mental Test Score (AMST) (Hodkinson, 1972) on admission to the service • Inpatient in acute care of the older person ward or a service user of an intermediate care community service at the point of recruitment 	<ul style="list-style-type: none"> • Under 65 years of age • Clinical Frailty Scale score of 4 (vulnerable) or lower or of 9 (terminally ill) • Moderate and severe cognitive impairment score of 6 or less on Abbreviated Mental Test Score (AMST) (Hodkinson, 1972) on admission to the service • Unable to speak English • Unable to give informed consent
Carer Cohort	<ul style="list-style-type: none"> • A recognised unpaid carer (UK Government, 2014) of a person aged over 65 years who has a Clinical Frailty Score of 5 to 8 who is currently an inpatient in an acute care of the older person ward or a service user of an intermediate care community service 	<ul style="list-style-type: none"> • Unable to speak English • Unable to give informed consent
Healthcare Professional Cohort	<ul style="list-style-type: none"> • A registered healthcare professional who works with older people who have a Clinical Frailty Score of 5 to 8 in either an inpatient in acute care of the older person ward or an intermediate care community service. • Contact with an older person making reference to '<i>their confidence</i>'. 	<ul style="list-style-type: none"> • None, however sampling method will identify exclusions as the study progresses.

Consent

There were separate cohort consent forms for the three participant groups. For older people and carers consent forms were given out alongside participant interview sheets when in the acute or intermediate care services. These were later reviewed and formally signed prior to any phenomenological interview taking place. The consent form documented informed consent obtained by the Chief-Investigator in line with ethical procedures to conduct research. The participant's right to withdraw consent at any point during the study was confirmed before finally proceeding with data collection.

Data collection method

Interviews are well suited for experience searching study design (Braun and Clarke, 2013). van Manen recognises interviews as useful sources of data to explore phenomena through capturing lived experience descriptions, with his approach of *conversational interviewing*, specifically used for gathering rich experiential narrative material and used to explore meaning of experience in a conversational relation with the participant (van Manen, 1990: 66-68).

Therefore, the opening question was always very specific to each individual, tailored around how the trigger word of confidence, was heard by the referrer. For example: *A few days ago now you spoke of your confidence being low when talking to the occupational therapist about going home, can you recall that conversation with them?*

van Manen (2017a) notes that without some interview structure it is unlikely for any human insight of experientially accessible or recognisable discovery to occur. Anticipating potential difficulties in establishing a connection to the original experience, a range of simple enquiry questions were prepared, based on the current lines of enquiry.

Interviews were arranged by the researcher, on first contact and after reviewing together the participant information sheet, negotiating a suitable time and place for the interview. Data were collected in the following locations for the three different participant cohorts:

- Older people were given a choice of having an interview whilst still in hospital, if medical treatment had finished and they were awaiting discharge arrangements (stranded) or later at home following discharge.
- Carer cohort interviews were conducted in the participant's own home.
- Healthcare professionals' interviews were conducted within contractual time (locally negotiated by the researcher) in a quiet, private on-site room.

Braun and Clarke (2013) emphasise the importance of location: quiet, private, comfortable, and safe for both the participant and the researcher. Consideration was given by the researcher of sensory impairments, communications needs, attention levels, fatigue (Peel and Wilson, 2008) and responded to accordingly. One large print copy of the participant information sheet was produced for an older participant and several asked for the participant information sheet to be read aloud to them because of visual impairment and/or reading difficulties. The Chief-Investigator conducted all interviews with the three participant groups. Interview duration was anticipated to be no longer than sixty minutes, a mean

duration from reported studies of older people with frailty by Peel and Wilson (2008). Interview data (conversations) were digitally recorded.

A sequential approach to overall data collection was taken (Figure 11), starting with a small number of patient interviews conducted, transcribed and initially interpreted before introducing interviews with carers and later healthcare professionals. This enabled the lived experiences of the older people to influence the start and end of the study. Interviews and follow-up feedback requests (postal, email or telephone) were to inform ideas of practical application of the emerging concept.

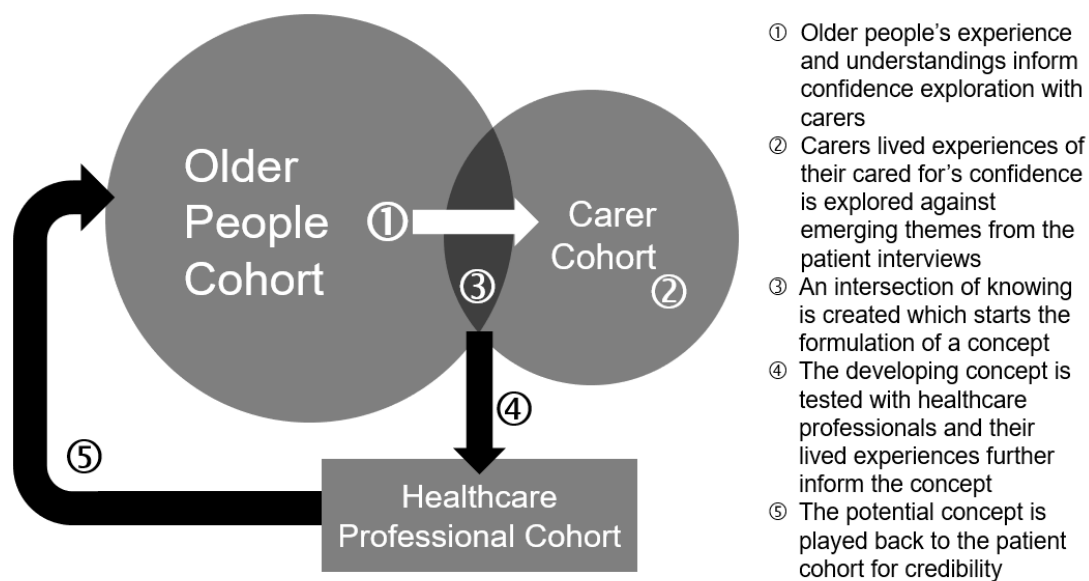


Figure 11: The sequential interview strategy for the phenomenological enquiry.

Data analysis

These data, conversations of human experiences, captured from differing perspectives (the frail older person, the carer of a frail older person and the

healthcare provider of that person) were transcribed verbatim by the interviewer using an adaptation of the Braun and Clarke (2013) notation system (p.165) from the digital recordings by the researcher to allow the most complete interpretation to support the methodological approach to human science being used. The final transcripts were prepared with line numbering to aid referencing of spoken text in the thesis. All transcripts were anonymised.

Interviews of older people underwent full phenomenological analysis as set out above using the steps in Table 10 and illustrated by the sample transcripts included in Appendix 3. The interview data from the carers and healthcare professionals were analysed in context of informing, enlightening, confirming or contradicting emerging ideas from the analysis of older people interviews.

A follow-up activity was included in this study to consider the credibility of essential themes emerging from the analyses (Lincoln and Guba, 1985). A follow-up study-outcome pack was created and distributed by post and or email to all consenting follow-up participants to review the research outputs. This follow-up activity was agreed as part of the study protocol and received ethical approval.

Ethical considerations

The NHS Health Research Authority (HRA) recognises two groups in the UK population as vulnerable when it comes to participation in research: children and young people and adults (anyone aged 16 and over) not able to consent for themselves (Health Research Authority, 2018). Adults with cognitive impairment were excluded from the study on ground of uncertainty of contribution as recalling recent experiences of confidence was necessary. However, Ilgili et al.

(2014) recognise the broader vulnerability with older participants, especially those with chronic mental health conditions, cognitive impairments, care home residents and those terminally ill, that research should consider. They argue the importance of participation and promote having the right protection measures in place, especially in respect to their *deference to authority, obedience, and submissive dependency on others* that can lead to manipulation and coercion (Ilgili et al., 2014: 6-7). This study recognised the most vulnerable were the older people participating and potentially the carer group, acknowledging the increasing number of aging informal carers within society and the high level of adverse effect this has on their mental health (Carers Trust, 2015). Ilgili et al. (2014) argues that good study design and careful consideration of appropriate protection measures are crucial to allowing participation of these often-underrepresented groups in the literature. Physical and psychological risks of harm were considered in this study design. Mitigation of risk was either scheduled in the study protocol or fell to the researcher to act professionally in the best interest of the person. For example, within the study design two key mechanism supported confidence in selection. The exclusion criteria ruled out people unable to consent through the check of abbreviated mental test scoring on referral to the study by the healthcare professional, but also if the researcher was concerned at first contact they sought confirmatory support from the patient's consultant to proceed, when the opportunity was available again. Two potential participants were excluded by the researcher on referral. The second mechanism was the staged approaches to final participation, giving time to reflect on the opportunity and to withdraw consent if feelings of coercion or

pressure to participate were experienced. This opportunity was taken advantage of by five participants.

The HRA requires all researchers to be appropriately trained and qualified for the research activities they undertake. The researcher therefore undertook the Good Clinical Practice (ICH-GCP) training which allowed them to implement the internationally recognised ethical and scientific quality requirements that must be followed when designing, conducting, recording and reporting research. The doctoral degree was supervised by an experienced researcher as University Director of Studies, additionally the study was overseen by the Research Sponsor of the researcher's employing NHS Trust. Adjunct to this research training, support and study oversight, the researcher is recognised as an experienced and expert clinical professional who frequently assesses cognitive vulnerability within legal frameworks set out in statute. Any concerns over capacity assessment for the patient participant cohort were therefore referred to the patient's consultant or lead clinician for a final decision to participate. However, this risk mitigation was not used. Finally, the researcher was trained to take immediate and all necessary action to safeguard and protect any vulnerable individual encountered.

Research ethical approval for the phenomenological aspects of the study was granted by the NHS Health Research Authority (Appendix 4) and the University of Plymouth Faculty of Health and Human Science Research Ethics Committee (Appendix 5). Both covered how participant and researcher welfare considerations were to be addressed and how confidentiality and data security were dealt with in concordance within current legal frameworks.

The original ethical approval was for the older people cohort to be interviewed in their own home (including their care home if that was their home). This initially worked well. However, as the study proceeded several barriers arose to accessing participants in their own home. Telephone contact with two participants to schedule a post-discharge visit time failed, no-one answered the phone on several attempts. Additionally, two carers declined further study participation on behalf of the person they cared for, one a neighbour and the participant's informal carer and the other the participant's son. It was unclear if this was taken in the capacity of advocate, acknowledging vulnerabilities (discussed in the ethical considerations section) or without their involvement and choice. It was in the context of a run of such access difficulties that the study protocol was revised and resubmitted to the research ethics committee. The amendment, which was supported, offered an interview for the older people cohort while in hospital (details stated in the data collection section above). Another interview consideration was in respect to judging and pacing the interview with a diverse group of older people. The final correspondence approving the protocol's non-substantial amendments are recorded in Appendix 6.

Appraising trustworthiness

Pereira (2012) presents a broad critique of rigour in phenomenology. She argues a position this researcher has echoed: that polarisation of philosophical and academic posturing makes much of this type of research unattainable to nurses and to evidence transfer into practice. She states:

A phenomenological study must take into consideration methodological congruence (rigorous and appropriate procedures) and experiential concerns that provide insight in terms of plausibility and illumination about a specific phenomenon. (Pereira, 2012: 19)

van Manen (2014) presents criteria for the appraisal of phenomenological studies (Table 12). This is adopted in Chapter 8 to evaluate this phenomenological study's strengths and limitations. A COnsolidated criteria for REporting Qualitative research (COREQ) checklist (Tong et al., 2007) for the phenomenological enquiry reported in this thesis is presented in Appendix 7.

Table 12: Criteria for Evaluative Appraisal of Phenomenological Studies.

Heuristic questioning – asking does the text induce a sense of contemplative wonder and questioning attentiveness?

Descriptive richness – does the text contain rich and recognisable experiential material?

Interpretive depth – does the text offer reflective insight that goes beyond the taken-for-granted understanding of everyday life?

Distinctive rigor – does the text remain constantly guided by a self-critical question of distinct meaning of the phenomena?

Strong and addressive meaning – does the text 'speak' to and address our sense of embodied being?

Experiential awakening - asking if the text awakens pre-reflective or primal experience through vocative and presentative language?

Inceptual epiphany – does the study offer us the possibility of deeper and original insight, and perhaps, an intuitive and inspired grasp of ethics and ethos of commitments and practices?

van Manen (2014: 355-6)

Ensuring the highest quality of qualitative research is essential. Trustworthiness is a qualitative researcher's equivalent to scientific rigor in quantitative research. It resonated thirty-five years ago with the then dominant positivist's worldview over four parallel criteria: credibility, transferability, dependability and confirmability (Lincoln and Guba, 1985).

van Manen states that the only transferable, or generalisable element of phenomenology is that it is *never generalisable* (van Manen, 2014: 352).

This reflects a common contention made of qualitative research. However, in the discussion chapter argument will be made regarding trustworthiness in the overall evaluation of the wider study. The appraisal of research validity is important to enable critical guidance by others and demonstrate scholarly endeavour.

Summary

This chapter has presented the rationale for choosing an interpretivist phenomenological method, based on the work of Professor Max van Manen. It has navigated the complexities of the philosophies and practices of phenomenology and articulated the human science methodological approach to the phenomenology of practice that guides this enquiry. The methods used for the phenomenological enquiry study have been detailed, critiquing approaches to the interview, and analysis to allow the lived experience to be reached. Appraisal criteria for assessing trustworthiness across the studies has been detailed.

CHAPTER 6:

THE LIVED EXPERIENCE OF CONFIDENCE: FINDINGS FROM THE PHENOMENOLOGICAL ENQUIRY

Introduction

This chapter presents the findings from the third stage and largest stage of the study. Twenty-three experience-based conversations were analysed, of which seventeen were from older people living with frailty. This chapter will firstly describe the study and participant characteristics, including reflections on the impact of the sequential approach adopted to interviewing participant in a hope to expose the phenomena (Figure 11). The main body of this chapter is dedicated to detailing the analysis, reflections and moments of discovery leading to the presentation of the enquiry's ultimate findings: four essential themes. These essential themes have been extracted from deep phenomenological analysis of the conversations with older people. Explanation and justification of these essential themes are given. These themes are then evaluated with interview data from the carers and the healthcare professionals who participated. Finally, for the phenomenological enquiry section of this chapter, the participant review of feedback is included.

Study and participants characteristics

The interview phase of this study took eleven months (between May 2017 to March 2018). This was much longer than expected, due to lower than anticipated levels in the usage of the trigger word, confidence, in practice. In total, seventeen older people living with frailty were recruited to take part in the study (Table 13). This was in line with the proposed sample size and recruitment target number.

Table 13: Characteristics of study participants.

Participant number	Category	Gender	Age	CFS	Admission trigger	Interview location
P01	OP	F	95	8	Fall at home	Home
P02	OP	F	90	7	Fall at home	Home
P03	OP	F	80	6	Fall at home – fractured pubic rami	Home
P04	OP	M	70	6	Fall at home – alcohol related	Home
P07	OP	F	87	6	Fall at home	Home
P08	OP	F	84	6	Fall at home	Ward
P09	OP	F	86	6	Fall at home	Ward
P10	OP	F	85	6	Fall at home – fractured humerus	Ward
P11	OP	F	74	7	Pulmonary embolism	Ward
P12	OP	F	85	6	Pulmonary oedema	Ward
P13	OP	F	79	6	Fall at home and haematuria	Ward
P15	OP	F	80	7	Fall at home and bilateral septic leg ulcers	Ward
P18	OP	M	90	7	Shortness of breath	Ward
P19	OP	F	80	6	Community acquired pneumonia	Ward
P20	OP	M	86	6	Discitis and duodenal ulcer bleed	Ward
P21	OP	M	87	7	Fall at home	Ward
P22	OP	M	82	7	Cardiac arrest - hyperkalaemia	Ward
CP01	Carer	F				Home
CP02	Carer	M				Home
HCP01	PT	M				
HCP02	OT	F				
HCP03	RN	F				
HCP04	RN	F				

CFS = Clinical Frailty Scale score; OP = Older Person; HCP = Health Care Professional; PT = Physiotherapist; OT = Occupational Therapist; RN = Registered Nurse; M = Male; F = Female

Older person participant recruitment took place from three inpatient ward areas. Sixteen additional older people were asked by the clinical teams to participate. However, through screening and subsequent follow-up they were either ineligible or dropped out. Two were assessed as not having capacity to consent; two were thought to be over 65 years old by the referrer but did not meet the minimum age inclusion criteria; three were unable to recall using the word confidence, so declined further participation; three were discharged before being able to be met by the Chief-Investigator; two had carers at home who refused follow-up on their behalf; one was uncontactable once discharged home; and three declined further participation (the scheduling of a home interview) once at home. In response to this high-level of dropout, a research protocol change was triggered as over half of the potential participants, once discharged, became inaccessible to follow-up. The amendment approved by the overseeing ethics committee allowed for interviews to be offered whilst still in hospital.

Participants 01 and 03 had a carer or family member present during their recorded interview. Participant 17 (carer participant) had his wife (cared for) present during the interview. Lower than expected levels of carers of older people living with frailty took part; only two, against a planned sample size between four to six. Many more were approached, often children of these older people. They cited time and other family commitments, their own children for example, as reasons not to participate in the study. There is additional carer insight drawn from an older person, study participant 22, that has been drawn into the wider analysis. Four healthcare professionals were recruited: a physiotherapist, an occupational therapist; a senior ward nurse and a ward sister.

Recruitment areas were an acute general hospital's intermediate care and discharge unit (an area for stranded patients (Oliver, 2018)) and two wards designated as older people wards, on a community hospital site, that support rehabilitation and reablement closer to peoples' own homes. Carers were recruited through contact with participants from these ward areas. Healthcare professionals targeted for participation, as planned, came from the core referrers of older people as participants into the study.

Interview durations ranged from twenty-two and fifty-six minutes across the participants. Two shorter duration interviews related to participant's inattention difficulties in one interview and one participant's low mood affecting participation; she became emotional and upset, and so the interview was halted and concerns about her mood raised to the medical team caring for her. One carer cohort participant did not want their interview to be recorded. Notes were taken throughout the conversation by the researcher and with the participant's agreement, these were typed up into a transcript type structure of question and answer format and shared back with them to review, amend if necessary and agree. A pre-paid envelope facilitated the return of a signed copy, confirming the capturing of an accurate conversation.

The proposed sequential approach to overall data collection (Figure 11), starting with the interpretation of a small number of patient interviews that would be used to inform later interviews with carers and then with healthcare professionals was useful and helped to inform later interviews. However, because of a lower than intended number of carers participants, it was not possible to reflect on lines of enquiry emerging from other interviews as

effectively as intended. The healthcare professional participant interviews came later in the process and for these, the emerging high-level ideas from the older people interviews – predominant around the physical, social and psychological aspects of confidence recognition and understanding – did inform the interview discussions. It was anticipated that this approach would enabled the lived experiences of the older people to influence the start and end of the study, and on reflection, as the phenomenological interpretive analysis focused solely on the lived experiences of the older people participants, this was achieved. The positive aspect were realised, in that staging participant recruitment grew a confirmability of ideas and probably strengthened data saturation assurance (described below in more detail). Weaknesses recognises the need for strong recruitment processes to deliver the numbers anticipated at the right time to fulfil its ultimate aim.

The saturation strategy was structured within post-interview reflections, following the first ten older people interviewed. The trigger to halt further interviews was when no new data emerged and with confirmation with research study supervisors. Participant 12 was the tenth interview of an older person, post interview reflective notes record:

The interview was short, but here again insightful into the strong connection to social connectedness and confidence... (P12, post interview reflective notes)

The review of newly elicited lived experience from this point grew depth and richness of the essence of confidence, but nothing new. The last reflection, from participant 22 notes:

Reflecting on whether I am hearing anything new, I feel not. The richness of this participant's lived experience of hopelessness connects into the

emerging dimensions of this study – significant physical impairment, the loss of control, leaving a raw desperateness to be independent and back home with his family. (P22, post interview reflective notes)

It was concluded here that saturation was reached, confirmed by supervisors of the study, and formal structured interview analysis commenced.

The follow-up phase of this research was structured around a postal study outcome pack. For some participants this came 21 months following their interview. Nine older people participants consented to follow-up involvement to review the findings of the research. Both carers agreed, as did the healthcare professionals involved. Prior to posting out the follow-up study outcome, an electronic hospital system confirmation of the current status of the older people participants was conducted. Of the nine, all were alive (two of the total cohort of 17 older people had died). Three had changed residency, moving to residential or nursing home care. No similar checks could be made on the carers. Healthcare professional were emailed the follow-up study outcome pack. Three older people participants responded. No carers responded. One healthcare professional responded. Their feedback is reported later in this chapter.

Staged approach to the analysis of interviews

First a practical illustration of the analysis is presented, before detailing core aspects of the findings from in-depth interpretation of these data. The three stage approach to analysis is described, following the structured methodological approach of human science: individual interview analysis; meaning and

understanding review and; guided existential inquiry (van Manen, 2014: 319-323).

Individual interview analysis – A holistic reading approach was adopted that created uniquely individual and evocatively written patient descriptions of lived experiences of confidence. These re-creations, or interpretations, of patient stories are extracted from very detailed phenomenological analysis of the recorded conversation and transcripts. This is illustrated in Table 14, reporting key extracts of the story from Participant 02, one of the oldest participant in the study, aged 90 and living with a severe level of frailty (a clinical frailty score of 7). She was admitted to hospital following a fall at home, and her interview conversation was conducted in her own flat one sunny afternoon in late May, approximately three weeks after discharge from hospital. She was still receiving intermediate care services into her home regularly each day.

Table 14: Data extract from the Individual interview analysis – describing the phenomena and identifying the incidental themes (Participant 02)

You lose confidence following a fall and when you lay there and cannot get up, but it's hard to explain. Lying there on the floor, you have a strange empty feeling, your confidence just takes something away. Confidence is about regaining something you have lost. It is connected to the need or desire to do something, something about the situation you are in. In your mind you cannot do these things – You have the desire, but not the confidence. It might be down to nerves and worrying about falling again.

Nervousness plays a part in your confidence. You can struggle to let go; letting go of the help and support intermediate care services have offered this last six weeks and worrying what that might mean. There is a nagging in your mind to keep some level of support going, it may be lonely otherwise, you might not manage. That nagging maybe more a fear of letting go and becoming dependent on just yourself again.

continued

Confidence starts to grow as you start to achieve things, being less dependent on carers for example. As you become more independent you don't need them to call in and support you as much. However, this contrasts with that other struggle you have to deal with, to feel confident to let go. Becoming less dependent on others is an achievement that helps your confidence to grow. It is a struggle to mentally get there, but you are determined to do so. Confidence is something you must work at. It builds as you achieve things, like walking well with your frame. You balance in your mind wanting to do well, with a fear of just doing it, it is scary.

Unique themes: (bold are stronger themes)

- **Falls affect your confidence**
- **Confidence means regaining and building back something you have lost**
- **You become confident when you achieve what you desire**
- **Being fearful (of falls and of loneliness) has a negative effect on confidence**

Unique incidental themes are all themes extracted from the analyses that uniquely and separately present. Incidental in the fact that at this point any essentiality is not determined. These were extracted from the data and then used to inform the next stage of this structured methodological approach to human science, which was developing a deeper meaning and understanding of these lived experiences.

Meaning and understanding review – An approach involving selective reading connected the direct quotes from participants' narratives to the identified incidental themes. Table 15 presents an extract from a meaning and

understanding review for the last incidental theme of Participant 02: *Being fearful (of falls and isolation) has a negative effect on confidence.*

These raw data in the form of direct quotations from the transcript serve to provide justification for the theme and also an indication of an overall strength and value (bold are stronger themes). Some incidental themes are not recorded as strong themes (bold), here the researcher is identifying something important emerging from the analysis, worthy of recognising and acknowledging its presence, but where supporting material and evidence for the theme is weaker.

Table 15: Data extract from the meaning and understanding review to evidence the incidental theme (Participant 02)

Being fearful (of falls and of loneliness) has a negative effect on confidence

Falling again (.) and your legs get wobbly. This is all part of the (.) and worry I suppose (.) and worry is all part of it. (P02 starts line 69)

I know I can do it but then I am scared to do it (.) and that where I have lost my confidence. (P02 starts line 91)

...because they say you're coming in in the morning, why are we bothering to come in because you are dressed and so (.) I suppose that is a step forward and that's what they are supposed to be doing, that [Intermediate Care Service]. But I don't have the confidence again to say don't come any more (.) not the sort of afternoon, the evening one I quite look forward to that one... (P02 starts line 111)

What's holding you back then, to say, to, to keep them coming in...

...fright. (P02 starts line 118)

continued

I don't mind being left alone I, I just don't know. Perhaps it is the fright of being left alone...

Or is it anything else?

No.

I don't want to put words into your mouth, its...

No, but they can (.) they say good night and I can get myself to bed and all that sort of thing... (P02 starts line 123)

Sometimes I think I'm better just left to get on with it now err, you know, 'You can do it, just get on with it' (.) right, which I hope I will soon. There's something, a little something at the back, a little bit nervousness... (P02 starts line 131)

Have a think, what do you think that niggle is that says, that says I'm not quite ready...

Fright, yes...

...its being frightened?

Yes, I suppose that covers it. (P02 starts line 138)

What's it like to lose your confidence after a fall? What does that feel like?

(.) well sort of strange empty feeling I suppose, urm, well I suppose it's fright (.) (P02 starts line 152)

The final stage of this structured methodological approach to human science analysis is the interpretation of the data:

Guided existential inquiry – this detailed analysis of the interview focuses on the interpretation of these data from an existential perspective. van Manen (1990) refers to these *existentials* as a series of *fundamental lifeworld themes* to

guide reflection (p101) later describing them as the *universal themes of life* (van Manen, 2014: 302): lived body, space, time, relation and things belong to everyone's life. This method is influenced by the work of phenomenology philosopher Merleau-Ponty (1908-1961), who, working in the field of descriptive psychology, acknowledged the Husserl's space and time connection to the primal impression of consciousness, the lifeworld, and goes further. Connecting to; human *embodiment* and the body's *relationship with other* and with other *things, such as* the material objects in our lives (van Manen, 2014: 127-131). The exploration of phenomenon in the lifeworld, of lived experience, will have connection to these five fundamental elements. Reflecting on this existential method, on how people experience the world in these conversations with research participants, enabled the analyses of findings, to attempt to expose the essence of the phenomena. They are explored more here and the details of participant 02's existential enquiry follows on (Table 16) :

Lived body, or corporality

This premise guides reflection of how a phenomenon is experienced by the body. This reaches beyond just being physically engaged in the world, living our life on Earth, that while we are alive, we will always do. It involves how an awareness of our body in the world appears to us, so as to experience it. Perception of the body through the senses: sights, smell, taste, touch and sound, and through emotional connections (feelings for the body, for example) can reveal corporal experiences beyond living experiences or life event and reach the existential experience of embodiment.

Lived space, or spatiality

Lived space is felt space, which exposes the spatial dimension of the immediate environment. Space and place felt, meaning experienced by all the physical senses and experienced emotionally, spiritually and psychologically, exposes a lived-world connection to a phenomenon. The space can be internal, a private space experience, connected to an outside place, for example experienced feeling of restriction and confinement in thought, as through you were locked away in a small prison cell. The boundaries of private and public space can expose a cause-and-effect relationship – an experience of lived space.

Lived time, or temporality

Reflecting on how time is exposed and experienced gives insight into the existential theme of temporality. This experience can be objective; celestial time (seasonal time or tidal time), calendar time or clock time. Or it can be experienced subjectively as phenomenological or lived-experience time. A lived-time dimension relevant to this study can see how aging is experienced, a time-lived or the lived-feeling of being old, as the way we feel can influence how we experience time. Finally, here, time can stretch back, be present and reach into the future.

Lived self-other, or relationality

This theme refers to how one's self is seen and how others are experienced in that seeing of oneself. It reflects on the relationships we make and may break with others in our life and how that is experienced. It involves the emotional and spiritual as well as the physical experiences of human relations.

Rationality can refer inward to our deep inner lifeworld as much as it can outwards to family, friends and community; a private and public experience. It can reflect animate lived-experiences, but also the inanimate, the relationships with things, with objects. The experience communicates the interactions and the spaces created between the relationships with individuals and with items.

Lived things (and technology), or materiality

Understanding how lived things are experienced can seem vague from outside a phenomenological stance because, what are things. Indeed, within the written explanation from van Manen, there remains a classic ambiguity in describing what things mean. Things here are interpreted to mean material objects and enable reflection on the technologies and technical state of things experienced. They can also describe the immaterial, as these often poses an association to what they are not, in the physical world. Lived things stretch to the macro-level of things, or the thing of things, and as such encounter the vastness and complexities of our elusive world and beyond our mysterious world.

Reflecting on the existential presentation of confidence for Participant 02, as interpreted by the researcher, are presented in Table 16.

Table 16: Data extract of the guided existential inquiry (Participant 02).

<p>Lived body: Physical falls are central to this participant's lived-experience of confidence. Her wobbly legs (line 69) are referenced as is her overreaching that has caused her to fear a fall (line 75), both bodily connections to confidence affecting falls. There is a constant narrative through the conversation linking her battle with frailty to the ambition of regaining her physical independence.</p> <p style="text-align: right;"><i>continued</i></p>

Lived space: The participants internal space is most evident in this conversation, her mind's role in overcoming this lived fear of falling is ever present. She talks it through to herself throughout the conversation: 'I can't do that, oh yes I will' (Line 76); 'I've got to walk with a frame ... my confidence will come back' (lines 85 and 87); and 'I've got the desire ... I'm independent' (Line 96). There seems a perpetual mind game of confidence promotion and management connected to her lived-experience of confidence.

Lived time: The only connections to time and confidence is recalled in her seeing herself age:

Because of the falls and I still have. And I'm not really back to how I used to be and I don't know whether I really will be, because I have got little bit older. Losing your confidence, you see (.) yes, its if (.) I can't explain exactly. (P02 starts line 33)

Exploring a little about health and frailty in the last couple of years she recognises her ambitions are not always as achievable: '...of course I've got older ... I can't achieve what I want to (...) and that is annoying in a way' (P02 starts line 166).

Lived self-other: This participant lives alone and mentions no others apart from the temporary cares visiting her from the intermediate care service. She describes, without being explicit, the worries of recovery being balanced with a loss of social contact. Confidence is entwined within this. She is clear confidence grows as you become independent and as you set your goals (your desires) to achieve. She worries about the withdrawing service staff. The sentence where she mentions missing them 'say good night' (line 128), really connects to the deep tension she faces, and sadness for a loss of social (of human) connection.

Lived things: In some way the entity of the intermediate care service that is attending her three times a day is seen in the conversations as a material lived-experienced connected intrinsically to her confidence. It holds confidence giving opportunity to meet her ambitions for independence with the negative aspect as dependency on the services poses a significant wrench when withdrawn. This contradictory emotional or psychological dependency that grows and maybe dependency is realised throws up the complexity of this lived-thing. Confidence is connected throughout this singular lived-experience of the intermediate care services. These services can be seen as societal or political things, responding to moving care from centralised and costly institutions (hospitals) to our more personal concern, those of our own homes, back in our communities.

Following the analysis of each interview a reflective pause was taken to consider and reflect on the epoché (suspension of judgment) and the reduction (exposure of the phenomena). This was an important part of the interpretive process, and explored how the researcher experienced the process, in terms of how they felt they were part of the process of discovery – both positively and maybe negatively. In Table 17, an example of one such reflexive account is presented, linked to Participant 02 again, which shows how notes from the immediate post-interview, post-analysis and later reflections were reviewed together.

Table 17: Exploring the epoché and conducting the reduction – a methodological examination of separation and the reductive reflection of the emerging phenomena (Participant 02).

This participant, like some others I later interviewed, could not re-call themselves talking about confidence whilst in hospital to the care team at the start of the conversation. Therefore, the start of this conversation I re-set the scene for her. This was based on the refers information and on the communication I had with the participant in hospital, where I talked about study participation.

Conscious of not wanting to lead this participant and introduce any bias (in the way of provoking sub-conscious thought to be come conscious, to emerge and start to be reflected upon) in data gathering. I was required to present some circumstance to her mentioning and talking about confidence in the first place. I believe I presented only factual prompts, taking her back to that time we met in hospital and hoping for the lived-experience she had then to appear to her now, and emerge in this conversation.
(post-interview notes)

Reading and re-reading the transcript, there reads a nice natural flow into her first descriptions of confidence. Therefore, followings some context setting, based on the fall experience she had recounted to me in hospital, it felt like we had a moment of

continued

mutual understanding – that explaining what confidence is, ‘is quite hard’ (line 35 and 36). From this, the natural emergence of regaining something lost came out (line 39) and later the desire to do something (line 44). These were her ideas that were sustained in the conversation. (post-analysis notes)

This was my very first interview of this study and my post-interview notes reflect the apprehension I felt. I noted how easy the conversation struck-up and started to flow, following the time taken to reset the scene at the start of the conversation. I recall how I felt, by re-connecting her back to her previous un-remembered experience of confidence loss.

I believe I reached her conscious lived-moment of confidence loss and her falls, where what she goes on to describe seemed to effortless and fluently flow. (post-interview notes)

In the conversation I asked her if she thought confidence was a physical or psychological entity (starting line 54), based on the findings of the systematic review. (At the start of these interviews I was uncertain how much the findings should be drawn into conversations, in a way to test their trustworthiness with lived-experience. Later in the study, they were only used a prompt when conversations struggled, in favour of natural conversations that were explorative of lived-experience, free from headings or claims.)

These introduced to her two abstract words to those descriptive words she was using in the conversation - of regaining confidence and desiring confidence. However, those words were not picked up on, she did not pre-consciously connect to them in her story. She did state that she thought confidence as both a physical thing and a psychological one (line 57) in response to my direct question, but really recognised:

“...in my mind I think I can’t do these things (.) I think that might be able to explain some of it (...) I haven’t lost the desire. I still have the desire to want to do it, but I haven’t got the confidence.” (P02 starts line 59)

Here, despite my clumsy question, I feel she is making an important connection to desire being a mental state of mind, a psychological association to confidence and being able again to ‘do these things’ links to a physical need that drives confidence. (post-analysis notes)

I write in my post-interview notes about my awareness of potential leading questions slipping in to conversations. I also note how I felt that the participant really thought

about the questions I was asking, and the positive use of silence enabled some further meaningful insights to this idea of confidence to emerge. The pause at line 169, where she is thinking back on her recent health situation, a pause to think about frailty, she acknowledges that she is getting older; that she is not able to achieve all that she wants to; and this annoys her, but she accepts it as inevitable.

When asked if she should just accept it, she laughs after starting a sentence where she says she doesn't really have to accept the situation if only she just had the confidence to do what she needed to do. The pause allowed her time to realise – it all comes [a]round to the same discussion again (line 173) - confidence. (post analysis notes)

The conversation felt like we were both exploring confidence's meaning, both adventurers unpicking its true understanding. I note in my records I repressed a 'reflection-in-practice' moment that may have influenced her told story by simplifying her experience of desiring to be independent (line 96) and substituting it with a short-cut, interpretive judgement to simply be all about her motivation. (post-interview notes)

This first interview informed me about the importance of having a fully open mind during the interview to allow all sorts of confidence connections to emerge and exist as they naturally are. The noting and recording of them, in the interview or post-interview are important and supports post-interview interpretation and analysis, as it allows me now to see if motivation emerged from the wider reading of the whole conversation, which it did not..

Linking confidence to thoughts on frailty were a little awkward, maybe shying away from the direct use of the frailty word. I spoke about her recent health and well-being (line 163). But interestingly she turned the conversation back to her desire to be confident and independent – getting back that thing that has been taken away. This conversation felt very much on-message for rooting out the essence, for her, of what confidence was. (post-interview notes)

Appendix 3 details the analysis from a selection of six of the phenomenological interviews. These have been selected to reflect the variety of participant experiences captured from interviews and to provide contextual reference in support of the detailed analysis.

Next follows the important and unique findings from the in-depth phenomenological analysis and interpretation of interview data from all seventeen older people participants.

Interview findings

These findings arise from the interpreted stories of confidence that give a powerful connection to the lived-experience. Detailed re-creations of lived experience stories have been extracted from phenomenological analysis of the recorded conversation and transcripts. These make a unique contribution to the previously sparse expressions of confidence, from the perspective of older people living with frailty, in the literature. Each of the seventeen participants evocatively speak about confidence in their lived story. Each one is rewritten in an attempt to connect the reader to the true nature of what confidence means to these people. van Manen (2017b: 814) describes these types of analyses of lived experience as the *data of phenomenological research*. The interviews are presented as narratives.

Participant 01 – Individual interview analysis

Worrying about being in hospital and the thought of not being able to come home affects your confidence. It also lowers your mood (making you become *low in thought*).

Looking at others around you when in hospital and seeing them getting on, makes you feel you can get on too. However, when you get home, and realise you are on your own, especially at night and that's a worry, you lose your confidence.

Losing your friends as you get older is not pleasant. You have memories of good times, but also bad times too, this leads to some loneliness that affects your confidence.

It hard to explain how the help received from an informal carer (a neighbour) helps your confidence. When you are not able to do something, they will always help, unreservedly. They come in in the evenings, every evening to check up on you, this helps you maintain your confidence. It is reassuring that someone is there and that they care about me enough to bother. You are not as confident in yourself when they are away on holiday for example, your confidence drops. You are always looking forward to when they come back.

Falling over and laying on the floor for a long time (up to eight hours), you are there trying to get up but struggling. In the end, realising you are not physically able to get up is a worrying experience that affects your confidence. Not having a lifeline to call for help leaves you feeling vulnerable. Now, having a lifeline makes you feel more confident, you can get help quickly. The being able to call someone, knowing someone will come and rescue you helps remove that fear of falling again and gives a boost to your confidence.

Unique incidental themes: (bold highlighted themes indicate stronger evidenced themes from the interview).

- Worrying about not getting home from hospital affects your confidence and mood.

- Looking at others like you, doing well, helps your confidence.
- **Knowing someone is there for you, looking out for you, is reassuring and helps your confidence.**

Participant 02 - Individual interview analysis

You lose confidence following a fall and when you lay there and cannot get up, but it's hard to explain. Lying there on the floor, you have a strange empty feeling, your confidence just takes something away. Confidence is about regaining something you have lost. It is connected to the need or desire to do something, something about the situation you are in. In your mind you cannot do these things – You have the desire, but not the confidence. It might be down to nerves and worrying about falling again.

Nervousness plays a part in your confidence. You can struggle to let go, letting go of the help and support intermediate care services have offered this last six weeks and worrying what that might mean. There is a nagging you in your mind to keep some level of support going, it may be lonely otherwise, you might not manage. That nagging maybe more a fear of letting go and becoming dependent on just yourself again.

Confidence starts to grow as you start to achieve things, being less dependent on carers for example. As you become more independent you don't need them to call in and support you as much. However, this contrasts with that struggle you have too, to feel confident to let go. Becoming less dependent on others is an achievement that helps your confidence to grow. It is a struggle to mentally get there, but you are determined to do so. Confidence is something you must

work at. It builds as you achieve things, like walking well with your frame. You balance wanting to do well with a fear of just doing it, it is scary.

Unique incidental themes:

- **Falls affect your confidence.**
- **Confidence means regaining and building back something you have lost.**
- **You become confident when you achieve what you desire.**
- **Being fearful (of falls and of loneliness) has a negative effect on confidence.**

Participant 03 - Individual interview analysis

Confidence means being independent and physically well. Confidence is affected by a fall and is connected to the inevitability of getting older and frailer. You lose your confidence when you fall, each fall takes a little bit more away and with it you lose your judgement. Losing your judgment, negotiating the home environment with poor confidence makes you hesitant, you are thinking about tripping over and seeing the things you can trip over, it is there all the time.

You can be particularly hesitant and lack confidence when going up and down stairs, especially when you are feeling weaker and less strong following a fall. Being taught techniques on how to get up and down stairs and using your stronger leg to steady you, gives you confidence – a feeling ‘you can do it’.

Losing your confidence or having your confidence knocked after a fall makes you more vulnerable. Dealing with or managing the things you used to do

before becomes more difficult. You worry about falling again. Building your confidence takes a while to do. You have to start building yourself up, rehabilitating yourself and setting out what you need to achieve next to see progress – goal setting. Your confidence grows when you set personal goals and you achieve them. Your confidence can grow with determination.

Unique incidental themes:

- **Confidence is connected to being independent.**
- **Confidence loss is caused by falls.**
- **Lacking confidence makes you more hesitant.**
- Losing your confidence makes you more vulnerable.
- **Teaching you new ways to manage helps your confidence grow.**
- Building your confidence takes a while.
- **Confidence can grow by setting yourself goals to achieve.**
- Confidence can grow with determination.

Participant 04 - Individual interview analysis

Multiple falls lead to you losing your confidence and that feeling you cannot manage as you used to. Losing your confidence means you lose your drive, your *get up and go*.

When you are coming home from hospital your confidence is affected. You think about how poor your mobility is following the fall, being restricted by using a walking frame and being alone, when you get home, affects your confidence. Alcohol dependence has connections to confidence too. For when you are

drunk you clearly don't worry about your confidence, however, when you are sober and face the consequences of the drink. An example is when sober you realise that the fall you have had creates a new dependency, a physical one. You then realise how on your own you are and that you are not managing at all well; all the things you drink to forget are the things that come back to negatively affect your confidence.

What confidence actually means is hard to put into words and explain. When confident you see yourself getting on well, managing. When you are like this you have a *jump* (line 165) in confidence, a boost. But falling over a second time, just takes it away. Once it's gone it's hard to get it back.

Unique incidental themes:

- **Falls take your confidence away.**
- **Coming home from hospital affects your confidence.**
- **Losing your confidence, you just feel you cannot manage (be bothered).**
- **Being restricted and confined by things out of your control affects your confidence.**
- Alcohol dependency can give and take away confidence.
- Getting back to normal gives you a confidence boost.

Participant 07 - Individual interview analysis

Being scared of having another fall affects your confidence, you are then always scared it's going to happen again. You are scared of slipping and losing your balance all the time. Your confidence then stops you doing the things you

used to do without thinking about it. You then worry you are becoming a burden of your family when you are this vulnerable. This worry affects your confidence too.

Unique incidental themes:

- **Confidence is affected by being scared of falling.**
- **Not being able to do the things you used to affects your confidence.**
- **Worry affects your confidence.**

Participant 08 - Individual interview analysis

Your confidence goes when you fall and when you cannot get back on your feet or if you fall and don't do anything to help yourself. Confidence loss should be a temporary state, provided you help yourself get over the obstacles in your way.

Confidence means 'get up and go', without it you can't do much to help yourself. You have to be determined, your determination to get on with it is connected to your confidence. You have to be determined to achieve these goals, this builds your confidence – you need self-belief. When you achieve your goals your confidence grows, and this can be seen. Others comment on the difference they see, and again this positive affirmation boosts your confidence further.

Determination and confidence is connected to your mentality and how you have been brought up. Being brought up to be independent and self-sufficient, many needed to during the war years for example, and being a farmer's daughter, working the land, shapes your attitude to get on and to have a determination to

achieve what you set out to do. There is a self-belief connected to confidence through this determination.

Unique incidental themes:

- **Confidence is lost when you fall.**
- **Confidence is connected to your determination to achieve your goals.**
- **Confidence is connected to being independent.**
- **Staff can help grow your confidence.**
- Confidence feels like something you need to reach for and grasp hold of.
- When you lose your confidence, you become lost too.
- Losing your confidence is frightening.

Participant 09 - Individual interview analysis

Confidence relates to the confidence you have in those caring for you as an older person living with frailty. The 'right type' of carer, one that gives you confidence, is the one with the right attitude, the right manner and one that is sympathetic. Their physical presence '*beside you*' is important, giving you a simple, a '*just able to see you*', level of assurance and an occasional reassuring hand on you that expresses support. Male carers give you greater confidence too, as they are stronger, able to support you if you stumble.

There is a fearfulness that when you call for help, the 'wrong type' of carer comes to help you. They don't have the same kind of time to help you. Carers in hospital are more likely to be the wrong kind of carer, as those at home with you

are more familiar with you and give you more confidence, as you are confident in them.

Being in your own home environment gives you a greater confidence walking about, as compared to being in hospital. In hospital there is a less familiar environment as the height of beds, chairs and distances are all wrong for you. However, being alone at home when you need help causes confidence to be lost.

Following a fall at home you are not as confident as you might think. It is the panic that sets in a little later, when you think you cannot carry on like this. When this panic sets in, you have to give yourself a good talking to, to not allow it to affect your confidence. Panic is connected to a lack of confidence as you age and as you become frailer and more dependent.

There is an element of comparing yourself with others while sharing a living space with others in hospital, particularly in a physical mobility and judging your limitation sense.

Unique incidental themes:

- **Support given by carers is important to give you confidence.**
- **Familiarity with your own home environment gives you confidence.**
- **Anxiety (panic and fear) has a link to confidence.**
- Comparing yourself with others more able than you reduces your confidence.

Participant 10 - Individual interview analysis

Following many falls at home that cause injury and long-lasting impairment, limiting your function, you lose your confidence. Confidence is linked to your ability to move around and to be independent. When you lose your confidence, it is important to have your family around you to help you get it back. Family support is helpful to you at these times, they help your confidence grow by adapting and accommodating to your new needs. There is a need for two-way respect in these situations to maximise your confidence. You will always worry about how much of a burden you may be on them though.

As losing your confidence following a fall is scary, you can quickly lose your independence and ability to move around. Wearing a life-line alarm to call for assistance, if you fall, gives you confidence. Regaining your confidence, you seem able to *manage* again, carrying out basic activities of daily living, such as going to the toilet independently and mostly getting in and out of bed with little help. Having others around helps your confidence too.

Unique incidental themes:

- A fall causes you to lose your confidence.
- Family and carers are connected to getting your confidence back.
- **Moving around independently is connected to the feeling of confidence.**
- Confidence loss is scary.
- Being a burden on others affects your confidence.
- Life-lines give confidence.

Participant 11 - Individual interview analysis

Communication has a central role to play in how your confidence is experienced and lived. In exploring frailty, even when your confidence is good, it exists in a delicate and fragile state. However, this balance can easily tip by being let down by poor communication. In these cases your confidence lowers, you can become easily intimidated and unable to defend yourself. You become more vulnerable and fragile. Poor communication can cause a mental torment that connects to your confidence and erodes it away. This personal, internal weakness is hard to admit to. Frailty feels like not being able to defend yourself, it makes you angry and this anger leads to frustration and disappointment. This frailty and lack of confidence is like being out-of-control, a helplessness, it can open you up to abuse. It comes on and goes slowly, it also has an accumulative effect and links to other factors, like physical weakness and loneliness. Fear, however, overrides all of this and has a destructive affect to your confidence. You need to fight fear to overcome low confidence. You must fight to say what you want to say. If you cannot defend yourself, you cannot have confidence.

Coming into hospital is a most frightening time, it is always linked to losing your confidence. In hospital you struggled to communicate, to be understood, to be listened to. Sometime when in hospital you are not in the right state of mind – delirium – it's like a mental stroke – you have strong, uncontrolled raw emotions, it feels like you are out-of-control, it is horrific. You might be in tremendous pain, but not able to get through to those around you – you lose confidence in them and the situation you are in. Or you may have a raging temperature, you feel frightened and unable to communicate effectively,

wanting to cool down by fighting your clothes off. You cannot make yourself understood, you quickly lose confidence in the whole system.

It is not just this mental torment where poor communication affects your confidence, living with physical weakness affects it too. Often people misinterpret your actual needs, and this leads to confidence loss. Because of this physical dependence on others you may need to live in a care home.

Experiencing, even temporarily, a care home can have a devastating effect on your confidence. You may witness and be subject to the most de-personalising experience through social isolation and the lack of mental and physical stimulation you can imagine. Good communication is confidence giving, but it is rare to truly find.

Living your life with a long-term mental health problem, with depression, is another example of where you can lose your confidence. It is one where communication with health professionals becomes important, but often through poor communication, trust and confidence are significantly affected and this in turn can have a detrimental effect on your health status and well-being.

Unique incidental themes:

- **Confidence goes when communication is not effective.**
- **Confidence is connected to fear.**
- **Confidence is lost when not in control of yourself or the situation you are in – a helplessness.**
- Depression can take your confidence away.
- Confidence is linked to social isolation.

Participant 12 - Individual interview analysis

Confidence focuses on functional physical activity attributes: the ability to get up from a chair, the ability to walk to the toilet, the ability to go and wash yourself. Being frightened of falling when carrying out these activities and being active is connected to the experience of your first fall, and the vulnerable state this left you in - being unable to attract attention to your situation or call for help. This frightening experience generates a fearfulness associated with daily living activities. This is a fear described as being present when walking for example and is a fear that holds you back from doing the things you want to do.

Confidence is also connected to loneliness and social isolation. The raw emotions of bereavement, through losing your spouse in later life; changes to established social networks with their individual connections and dynamics; loosing friendships and links to past journeys; feelings of becoming and being a growing burden on you children. These sentiments, as you become more dependent, have an emotional toll on your confidence. Family connections are important to help you feel confident and connected. However, the feeling of being a burden on others becomes emotionally charged and something else that is always on your mind. This view is reinforced when looking at the burden others with dependency and disability have on close family members and friends. You can see how dependency affects other people they socially connect with, relationships become more difficult and contact becomes less. In turn as, you get older and frailer you see how you are becoming that burden on your direct family, with your dependency. This dependency and its transferable consequences have a direct effect on your emotional well-being and

confidence. It may also influence how you see your own health and well-being needs – in a negative way, further affecting your confidence.

When feeling unwell and frightened (vulnerable), trusting others, healthcare professionals for example, to do as they say is important. Losing confidence, maybe 'losing faith' in others, can erode any state of well-being. Moving from hospital back home causes worry too, you question how well you will cope. This transition of care challenges the notion of confidence when being discharged from hospital, as it seems important that when in hospital you can get the help you want. Looking to going home, this is not so readily available. To go home and re-establish yourself with the cares and help you have around you at home needs a leap of faith, a mental adjustment, a shift of mind-set, that has an important connection to confidence too.

Unique incidental themes:

- **Confidence is connected to physical function.**
- **Falling and the fear of falling affects your confidence.**
- **Confidence is connected to loneliness and isolation.**
- Being a burden on others affects your confidence.
- Trusting others to do the right thing is important, otherwise you lose confidence.
- Confidence is necessary to have during transitions of care – from hospital to home.

Participant 13 - Individual interview analysis

Falling and having multiple falls 'knocks' your confidence. It causes you to worry about falling. The fear of falling is constantly on your mind, when walking or carrying out other daily living tasks, such as showering, this continuous fear affects your confidence. The way people talk to you, about your fall, can affect it too. Negatively, people can cause you more worry, telling you to *be careful, not to do this* or *not to do that*. These curtailments cause an apprehension that strips away your independence and this influences your confidence too. This may lead to isolating yourself from others and this has further consequences. However, having the right walking aid with you, to overcome the fear of falling, can help your confidence.

The other thing that 'knocks' your confidence is when those caring for you have the wrong attitude. They can be quick, strict, demanding and sometimes unkind. This attitude erodes your confidence – having someone caring for you overnight for example, someone that is sharp or short with you, makes you fearful to ask for help.

Exploring confidence through the life-course – confidence is something that is seen necessary to have and hold onto, to 'take you through' that life-course. However, as you get older, it is harder to keep hold of. As you get older, life seems to speed-up and keeping hold of your confidence becomes more important, but your general state of mental well-being needs to be strong to do this. There are two types of people with describable confidences. There are those born with it, they have good confidence 'from birth' and it takes them through life's course. The others are those who struggle with it from an early

age, at school, exam performance for example, they may be stifled by silly mistakes or nerves. This can have lasting and repeated consequences throughout life, with driving as another example, where nervousness can affect confidence and performance.

Getting old is frightening and becoming dependent on other people looking after you is too. Looking around at others in hospitals, you see their vulnerability, these older people are frightened and are lacking confidence, even to call for help. This is a fear you can see in yourself as you lose confidence, this is often associated with being in hospital and especially when not spoken to well. An abrupt doctor can affect your confidence, the same as that uncaring nurse you may have on night duty. At the end of your aged-life, the chance you need to go into care may arise. You hear stories and may experience life-long friends doing this and the may hear of the detrimental consequences this experience has on their confidence. It makes you fearful. You recall one such lifelong friend absolutely hating the idea, but recognised the necessity. However, the lack of stimulation, engagement and motivation (complete isolation) stripped away any confidence they may have. They disengage with everyone and withdraw. This plays on your mind as you become more dependent. You see confidence is ubiquitously with us (or not), virtually from cradle to grave.

Social isolation can be a self-imposed consequence of a sequence of falls, to protect yourself. You think you are not safe to go out and this leads to loneliness. You feel you are becoming a burden and you lock yourself away. You stop friends visiting, but with decreasing family contact too, isolation comes quickly. The knock-on consequence is that you start losing your confidence. The cycle of loneliness can be interrupted by visitors or by getting out of the

house, you realise, maybe too late how this can dramatically boost your confidence again. This often must be organised for you when the downward cycle of loneliness is set in, and when you may not be able to see it happening. When anxiety hits you, you become paralysed to help yourself. It is only through medication and the input of the community mental health team that the confidence lost (that results in not going out for a walk with your dog for example; not going shopping; not connecting to people generally or; not looking after your overall mental and physical well-being) can be helped. Recognising barriers to confidence loss are important. In these circumstances keeping a diary and identifying triggers for your anxiety can be worked through. Meditation and facilitated group support meetings help. Taking small incremental steps aid recovery, your re-engagement back with society and re-gaining your confidence again.

Unique incidental themes:

- **Being fearful of falling knocks your confidence.**
- Low confidence causes you to be frightened to call for help.
- Your walking aid gives you confidence.
- **The attitudes of others negatively affect your confidence.**
- Confidence has a life-course connection.
- **Social isolation and loneliness are linked to confidence loss.**
- **Anxiety and stress have a direct impact on confidence.**
- **Treating anxiety (with specialist interventions) boosts confidence.**

Participant 15 - Individual interview analysis

An unexplained onset of tiredness and fatigue nine months previously triggers a health decline and level of dependency, maybe frailty, now needing statutory support to remain living at home. Confidence is lost as increasing dependency grows. There is a recognition, but not necessarily conscious thought, that frailty and confidence do exist together, as frailty presents itself, confidence declines. Losing your confidence makes you more hesitant about the things you do. It is connected to losing your independence.

Losing your independence leads to losing control, the control over your life choices. You may desire to live independently, but as frailty and ill-health (specifically linked to mobility impairment associated with now chronic leg ulcers) create a dependency on others. Aspects of control are lost, and this affects your confidence. Control also plays into a fear of falling. Your mind controls what you feel and do, and if you have had several falls, this level of control becomes limited, impaired, and you are less confident when you need to get around.

Having hope helps you look forward to the future. Re-connecting back to social events that took you out of the house, this is one thing you hope for the most. Getting out to a club regularly, to meet with others and exercise, being active, this is something you can hope for, it's a way to get you back to how you were before, before your dependency grew and your confidence started to ebb.

When in hospital, talking about your confidence to others, in the context of preparing for home, makes you think about how you will manage and cope. It's really useful.

Unique incidental themes:

- **Frailty and ill health are connected to confidence.**
- **Control and 'getting back to normal' are linked to confidence.**
- **Social connections are important for your confidence.**
- **Talking about your confidence in hospital helps you prepare for discharge.**

Participant 18 - Individual interview analysis

Confidence needs to be built up before you go home following a long hospital stay. To get back up on your feet after you have lost your strength (after being deconditioned) in hospital, you need to be determined.

There is a degree of acceptance, as you get older, you cannot do the things you used to, and you have not got the things around you, you used to have (loss).

There is now a growing dependency on others, and this affects your confidence.

Unique incidental themes:

- **Confidence is connected to your physical strength.**
- **Lived-loss and confidence are connected.**

Participant 19 - Individual interview analysis

Confidence is being able to get up, to walk about and to hold you balance, and not to fall over - *to get on*. However, in addition to this practical and physical connection to confidence, confidence is particularly affected by your faith and by other people around you.

Regarding faith, this gives you confidence to carry on, even when coping with the loss of loved ones very close to you. Losing your children in your own lifetime can leave you without confidence to carry on. It leaves you low spirited, low in mood, lonely, desperate and very sad. The strong spiritual connection that faith can give, at these low points in your life, put things, the wider-world, into perspective for you. Your faith and belief allows your confidence to get on, to come back. Meeting people with the same faith is a great help to your confidence too at these times, as is having other family and friends around you, especially in later life.

The other important factor that affects your confidence, in a positive way, are associated with people around you. They may be formal carers, your family, friends or neighbours they can improve your confidence, with kindness. They can pick you up and lift your confidence. Equally, if they are unkind, and uncaring they can erode and wear away your confidence. This eroded confidence leaves you not wanting to get on, to walk, to eat, not wanting to do anything really. The unkind attitude of others can take your confidence away and leave you feeling low in mood and a little helpless. Sometimes you see that these cruel and mean people behave like that because they lack confidence themselves, this low esteem and confidence causes this behaviour.

Other things that affect your mood also affect your confidence. Having animals and pets around you helps boost your confidence, this connection to other things. Being in a familiar place, at home help your confidence too.

Unique incidental themes:

- Confidence is being able to get up and get on.
- **Having faith (religious belief) gives you a confidence.**

- **Others around you who are kind can help your confidence.**
- **Others around you that are unkind or uncaring can erode your confidence.**
- **You can see others who have no confidence affect your confidence.**
- Pets and animals boost your confidence.
- Determination and confidence are connected.
- Being at home after being in hospital boosts your confidence.

Participant 20 - Individual interview analysis

Confidence is something that is difficult to describe. It is a word we don't use that often, but it is useful to acknowledge and relate our recovery to.

Confidence is like riding your bike or driving a car – you don't think much about it at the time, but it is evidently there when you do. It is inbuilt, built into your body and into your mind. Mostly, you just get on with things and you don't notice it is there, it is rarely in our conscious thought – until we think about it – then you do notice its presence. Confidence is in everything you do, but often not visible or associated with every job we do. It is only when you lose your confidence you recognise it not being there.

Confidence is being in control. You need to know the rules. You need confidence to face the physical problems your body throws at you, a fall for example. The word confidence is more a mental attitude, it is something in your head. It helps you achieve your ambitions. You can gain confidence by understanding the rules. It is connected to your recovery – as you physically

progress your confidence improves. It all comes together – the body, the physical thing and the head, the confidence thing. Something your physical progression is ahead of your confidence, it must catch up on your physical recovery.

Unique incidental themes:

- **Confidence is being in control.**
- **Confidence is a mental attitude connected to physical recovery.**
- Others help build your confidence.
- Falls, balance and confidence have a connection.
- Confidence is gained by understanding the rules.
- Confidence is unconsciously omnipresent, you only become aware of it when you lose it.

Participant 21 - Individual interview analysis

Confidence in previous life roles, at work for example, give you an understanding of confidence later in life and helps you think about confidence and the connection with frailty. At work your confidence is high, and it grows with accomplishment, success and positive feedback. You present this confidence in the way you present yourself, your home, your life to others.

Getting older and seeing frailty appear is not easy, you see your physical health *fritted* away by the frustration of not getting around so well and falling over. You feel it – not just feeling *a bit achy* and slowing up, but you feel it when walking, when slipping over, and banging into things. When you feel your frailty you have

low confidence, you feel... it's hard to describe, *you feel buggered up*, it's frustrating.

You get so angry with yourself when you fall over. You see it all happening. Not using your stick to get around and just relying on the furniture. You fall. Despite your stick giving you that little bit of confidence, you often think it is easier to hold on to other things to get around.

Confidence is bound up in happiness and friendship – connecting to your social network brings this.

Unique incidental themes:

- Confidence is connected to accomplishment and success.
- Confidence is connected to increasing dependency.
- Walking aids give you confidence, if you use them.
- Confidence is bound up in happiness and friendship

Participant 22 - Individual interview analysis

Confidence means having will power – the will power to do things and achieve things.

Being put down by others when you are younger, by your family and friends, and having to find your way in life affects your confidence. It knocks you back. Fighting back however, you become a stronger person, a more confidence person and you can succeed in your ambitions. You learn to rise above it, and you learn not to take notice of others. You get on that way, you achieve your goals. You may look back and see that as you took on a caring role for someone you loved, who has now become dependent on you, you need

confidence to overcome the many challenges you now newly face – saying *I can do that!* is related to your confidence. Determination, being determined – a *I'm going to do it!* spirit is connected too.

As you get older and frailer your fighting-spirit changes. Now your physical strength starts to let you down. The more it lets you down you start to get depressed. You want to be able to do things for yourself, as you have done before, but you cannot. Even standing up out of bed is impossible. You lose your confidence and you become afraid. Not having the ability to get up out of bed is frightening. You have no confidence. You question why you have ended up in this situation, bed bound, physically disabled yourself, not able to do the simple things to help yourself, it's helpless, you see in yourself you are not improving, there is no way forward, it is so upsetting – you just cry.

Unique incidental themes:

- **Having a determination gives you confidence and the will to fight on.**
- **Confidence loss is connected to being afraid for the future.**
- **Confidence and depression are connected.**
- **Losing confidence and hope is emotionally upsetting.**

Essential theme analysis and development

A total of ninety-one unique incidental themes were identified from the interviews with older people participants (see Table 18), all connected in one way or another to the lived experience of confidence of these participants.

Table 18: Unique incidental themes extracted from the phenomenological interviews with older people.

Participant 1	<ul style="list-style-type: none"> • Worrying about not getting home from hospital affects your confidence and mood. • Looking at others like you, doing well, helps your confidence. • Knowing someone is there for you, looking out for you, is reassuring and helps your confidence.
Participant 2	<ul style="list-style-type: none"> • Falls affect your confidence. • Confidence means regaining and building back something you have lost. • You become confident when you achieve what you desire. • Being fearful (of falls and of loneliness) has a negative effect on confidence.
Participant 3	<ul style="list-style-type: none"> • Confidence is connected to being independent. • Confidence loss is caused by falls. • Lacking confidence makes you more hesitant. • Losing your confidence makes you more vulnerable. • Teaching you new ways to manage helps your confidence grow. • Building your confidence takes a while. • Confidence can grow by setting yourself goals to achieve. • Confidence can grow with determination.
Participant 4	<ul style="list-style-type: none"> • Falls take your confidence away. • Coming home from hospital affects your confidence. • Losing your confidence, you just feel you cannot manage (be bothered). • Being restricted and confined by things out of your control affects your confidence. • Alcohol dependency can give and take away confidence. Getting back to normal gives you a confidence boost.
Participant 7	<ul style="list-style-type: none"> • Confidence is affected by being scared of falling. • Not being able to do the things you used to affects your confidence. • Worry affects your confidence. <p style="text-align: right;"><i>continued</i></p>

Participant 8	<ul style="list-style-type: none"> • Confidence is lost when you fall. • Confidence is connected to your determination to achieve your goals. • Confidence is connected to being independent. • Staff can help grow your confidence. • Confidence feels like something you need to reach for and grasp hold of. • When you lose your confidence, you become lost too. • Losing your confidence is frightening.
Participant 9	<ul style="list-style-type: none"> • Support given by carers is important to give you confidence. • Familiarity with your own home environment gives you confidence. • Anxiety (panic and fear) has a link to confidence. • Comparing yourself with others more able than you reduces your confidence.
Participant 10	<ul style="list-style-type: none"> • A fall causes you to lose your confidence. • Family and carers are connected to getting your confidence back. • Moving around independently is connected to the feeling of confidence. • Confidence loss is scary. • Being a burden on others affects your confidence. • Life-lines give confidence.
Participant 11	<ul style="list-style-type: none"> • Confidence goes when communication is not effective. • Confidence is connected to fear. • Confidence is lost when not in control of yourself or the situation you are in – a helplessness. • Depression can take your confidence away. • Confidence is linked to social isolation.
Participant 12	<ul style="list-style-type: none"> • Confidence is connected to physical function. • Falling and the fear of falling affects your confidence. • Confidence is connected to loneliness and isolation. • Being a burden on others affects your confidence. • Trusting others to do the right thing is important, otherwise you lose confidence. • Confidence is necessary to have during transitions of care – from hospital to home.

continued

Participant 13	<ul style="list-style-type: none"> • Being fearful of falling knocks your confidence. • Low confidence causes you to be frightened to call for help. • Your walking aid gives you confidence. • The attitudes of others negatively affect your confidence. • Confidence has a life-course connection. • Social isolation and loneliness are linked to confidence loss. • Anxiety and stress have a direct impact on confidence. • Treating anxiety (with specialist interventions) boosts confidence.
Participant 15	<ul style="list-style-type: none"> • Frailty and ill health are connected to confidence. • Control and 'getting back to normal' are linked to confidence. • Social connections are important for your confidence. • Talking about your confidence in hospital helps you prepare for discharge.
Participant 18	<ul style="list-style-type: none"> • Confidence is connected to your physical strength. • Lived-loss and confidence are connected.
Participant 19	<ul style="list-style-type: none"> • Confidence is being able to get up and get on. • Having faith (religious belief) gives you a confidence. • Others around you who are kind can help your confidence. • Others around you that are unkind or uncaring can erode your confidence. • You can see others who have no confidence affect your confidence. • Pets and animals boost your confidence. • Determination and confidence are connected. • Being at home after being in hospital boosts your confidence.
Participant 20	<ul style="list-style-type: none"> • Confidence is being in control. • Confidence is a mental attitude connected to physical recovery.

continued

	<ul style="list-style-type: none"> • Others help build your confidence. • Falls, balance and confidence have a connection. • Confidence is gained by understanding the rules. • Confidence is unconsciously omnipresent, you only become aware of it when you lose it.
Participant 21	<ul style="list-style-type: none"> • Confidence is connected to accomplishment and success. • Confidence is connected to increasing dependency. • Walking aids give you confidence, if you use them. • Confidence is bound up in happiness and friendship.
Participant 22	<ul style="list-style-type: none"> • Having a determination gives you confidence and the will to fight on. • Confidence loss is connected to being afraid for the future. • Confidence and depression are connected. • Losing confidence and hope is emotionally upsetting.

Essential theme analysis and development

The next major step on van Manen's human science methodological approach and its ultimate ambition, is to identify essential themes to this lived experience. Distinction needs to be made between incidental themes and essential themes. He notes this to be the most difficult and most controversial element of human science. Determination of an essential theme concerns the view that, if it were to be excluded, the phenomena would no longer be what it is. van Manen calls it *free imaginative variation* (1990: 107).

It was immediate clear that the incidental themes could be grouped together where commonality could be clearly seen. Indisputably a connection between confidence and falls was evident, as was emotional connections. There was something about determination to regain confidence through being independent

that connected many themes, and clearly a confidence connection between the individual and others in their lives. These gave a useful starting point when looking for these similarities in lived experiences of confidence and they were used to revisit the transcripts to determine where these incidental themes emerged again. In doing so, the collection of associated words and, more importantly, referenced experiences were gathered and these either strengthened the essential theme's development or weakened it. Reflective notes, which. The cognitive and the written sketches and notes of emerging themes were connected, through the process of reading, writing, reviewing, and rewriting, a process advocated by van Manen (2014). Finally, through reflecting-in and -on each theme as it emerged, this phenomenological approach revealed four essential themes:

- The dimension of social connections
- The dimension of fear
- The dimension of independence
- The dimension of control

In Figure 12 the elements that were interpreted and created from the incidental theme review, and further intensive interview analysis, can be seen as contributing to the emergence of these four essential themes.

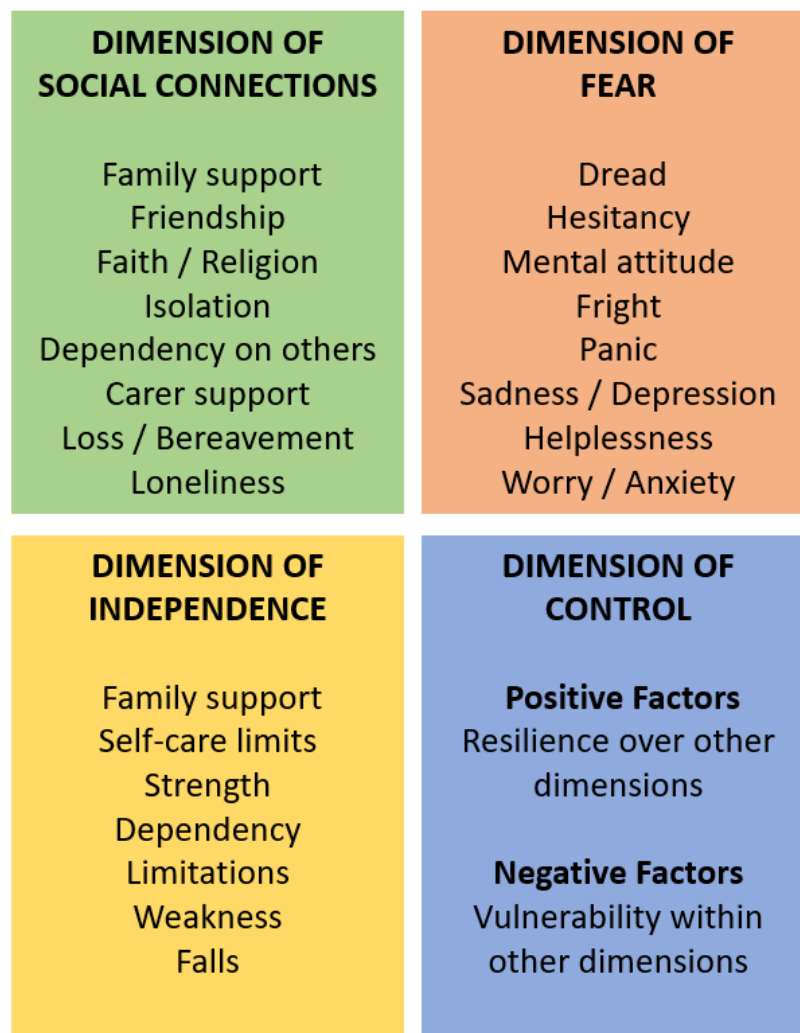


Figure 12: Illustration of the four essential themes and key words that emerged from the seventeen older peoples' interviews.

Each of these four essential themes are described, explored, and contextualised below.

Essential theme one: The dimension of social connections

Key words that contributed to the essence of this unique dimension of social connections are illustrated in Figure 13.



Figure 13: Illustration of the dimension of social connections and key words that emerged from the seventeen older peoples' interviews.

The interviews revealed that there was a bond (or link) between relationships the older person living with frailty had with family and friends (interpretation of family meaning: spouse or partner, siblings, their partners and children and other relatives close to them). This experience of confidence also existed in relationships between older people and their neighbours or paid carers, and health care professionals in the hospital and in the community.

Participant 19, for example, illustrates a number of these key elements, in this dimension of social connections in her lived experience of confidence loss and recovery. She starts by describing her family losses:

I felt I did not want to go on ... I lost my husband, five years before [name of son] died. So, I did not have much confidence left in anything to be quite honest with you.

What did that feel like?

Lonely, desperate, and very sad ... (Participant 19, starts line 29)

This participant spoke of feeling suicidal at this time. She describes her faith as central to her confidence:

I turned to our Lord and he gave me the confidence to carry on. And he said, 'You are not by yourself [name of participant], I'm with you all the way'. (Participant 19, starts line 18)

A lived experience was recounted as the interview prompted understanding of how confidence returned:

... describe how your confidence started to come back?

Well when it come back [.] I always remember, I was in bed and I was crying. I was sitting in bed thinking of [names of Son and Husband] and I was crying and I felt something like that [gestures touching / brushing her cheek], past my face and I thought, 'Its' our Lord' and you know ever since that I put my own trust in him and I done everything I could, and I felt warm. But lonely and warm inside, you know erm, 'cos I know someone was there who really loved me [becomes up set]. Sorry I'm a bit tearful my darling. (Participant 19, starts line 64)

The description of this element of social connections, drawn from all seventeen interviews, is described in Table 19.

This description of the dimension of social connections to confidence, as an essential theme is unique in that the essence of confidence cannot exist without its presence. It is hard to see or feel this confidence, exposed in the conversations, without the presence in some way of this social-bond or connection. Over two-thirds of the participants' incidental themes had a social connection to others (Table 18).

Table 19: The dimension of social connections.

The dimension of social connections
<p>The social connection of others to an older person's confidence is as unique as the individual themselves. This interpersonal connection is relational, it is a social association between them, the significant other in their life and then directly to their confidence. This dimension takes countless forms and characters. It appears as a social bond that forms and shapes their confidence. These social bonds, or connections can be with family; partners, husbands or wives, with daughters and sons, or with siblings and their children. They may be with: friends; with neighbours or carers; with health professionals in hospital or in the community; or with a religious faith and spiritual being. In turn, these social bonds, these personal, social connections to confidence can be strong or very fragile. In strength the connection with family, friendship and companionship gives confidence, hope and optimism. If this bond to others is broken, either permanently or temporarily; through loss of a spouse or abandonment of friends, or to the fleeting trust held in the carers supporting them, this broken connection leaves a person holding on to a frail confidence; a vulnerable confidence.</p>

The guided existential enquiry of lived self-other (the existential relationality) always found an important social connection to confidence. An illustration of this is shown here, with reference to quotes from the interview transcript, (indented):

Lived self-other: This participant lives alone and mentions no others apart from the temporary carers visiting her from the intermediate care service. She describes, without being explicit, the worries of recovery being balanced with a loss of social contact. Confidence is entwined within this. She is clear confidence grows as you become independent and as you set goals (your desires) to achieve. She worries about the withdrawing of service staff as she recovers. The sentence where she mentions missing them 'say good night' (line 128), really connects to the deep tension she faces, and sadness for a loss of social (of human) connection. (P02, Guided Existential enquiry extract)

[talking about her recovery with help from the intermediate care service, she states] I suppose that is a step forward and that's what they are supposed to be doing ... But I don't have the confidence again to say don't come any more (.) not the sort of afternoon, the evening [visit], I quite look forward to that one...

... I don't mind being left alone, I just don't know. Perhaps it is the fright of being left alone...

Is it anything else?

... they say, 'Good night', and I can get myself to bed and all that sort of thing... (P02, starts line 114).

Further illustrations of the domain of social connections (Table 15) from interview transcripts highlight associations to isolation and confidence.

Participant 12 recalled the people she is no longer connected to, and stated:

...you know I wish sometimes I could see more people you know. But, they are all like me, poorly and they can't get out [...] or they are tied up with others. (P12, start line 114)

Thus there is a link with relationship pressures and feelings of burden.

It's horrible really, cos you get up and go when you have got confidence and I'm afraid I've not been able to do that for a long time. I just think, well I am a nuisance to my son [becomes upset and cries]. (P12, starts line 28)

This indicates how difficult and uncomfortable relationship connections affected her poor confidence. It is also clearly reflected in the recollections of Participant 7:

Lived self-other: *In this paragraph (starting line 21) she mentions family and carers reactions to her falls. She lives with her daughter and sees herself like her, a worrier (line 46) and clearly the burden through her visible dependency she feels transferred on to her family. This is brought up when exploring the meaning for her of confidence:*

I don't want to feel I'm much trouble to everybody else as it were, with my family like, you know, it's a trouble for them. (P07 starts line 41)

Essential theme two: The dimension of fear

The high prevalence of falls connected to participants' lived experiences of confidence were notable. Many participants were able to describe the impact of poor confidence in relation to their fall(s). Eleven of the seventeen had their hospital admission triggered by a fall and a further two related a confidence connection to a fear of falling in their conversations.

Here a participant talks of hesitancy holding her confidence back on returning home, after an admission following two consecutive falls at home:

I'm more hesitant (...) more hesitant. So that tells me my confidence is not good at the moment and I'll need to build it up. (P03, starts line 23)

van Manen's *free imaginative variation* test (1990: 107) was then considered: does the phenomena exist if the essential theme was removed? Analysis found that the theme of falls was not recognised as an independent essential theme. In other words, in removing the notion and context of the fall, confidence remained present. Therefore, despite falls having many connections to experiences of confidence, they were not at the root of all confidence experiences. Rather, a consistent connection to fear being at the root of confidence loss in all cases was found. Therefore an essential theme emerged that connected to a dimension of fear (Figure 14).

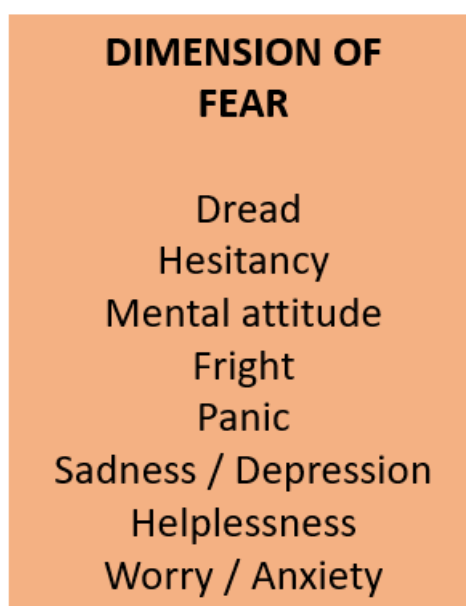


Figure 14: Illustration of the dimension of fear and key words that emerged from the seventeen older peoples' interviews.

This fear factor was powerfully seen in the lived experience of Participant 11, for example. She lived with depression and recalled her helplessness as confidence was taken away by her delirium experience in hospital. She described her significant confidence loss:

I wanted to throw [the bed clothes] all off and they wanted to put them back on and we came to quite a few tussles before they realised ... my actual temperature wasn't high, ... I just felt hot all the time and once I could get that coolness, as I was allowed to take my clothes off and sit in front of this fan, I was as good as gold because I was communicated to. ... But, the fear, in that is terrible because you can't do anything to get through. You lay there hour after hour, you think, what are you going to do, how are you going to communicate, how are you going to get through to them, you're in agony. You need to take these things on. Erm, yes they were hard times, yes frightening times. (P11, starts line 160)

... you got to acknowledge you can't fight the fear because without that confidence to fight the fear you won't fight it. That's what I feel, why can't everyone feel confident, why do they have to become frail and er, vulnerable ... (P11, starts line 233)

Fear's connection to confidence is central to Participant 13's story of living with anxiety and depression.

I went to bed one night, woke up the next morning and thought, 'God, I feel awful' and it wasn't what you call a mental breakdown, they called it anxiety and stress ... if it hadn't been for the mental people, which were there again, they gave, bit by bit your confidence back. What happened to me and that was dreadful, I'm still on medication for that, but I don't care what I take, as long as it keeps them away. (P13, starts line 168)

Here she described how the mental health team made her *stronger*. She next talked of how her confidence grew through addressing her fear, her returning to shopping independently:

You've got to go in [to the supermarket], even if you just poke your head in the door, you know, that one step nearer and that's gaining you a little bit more confidence and that's how it went. (P13, starts line 183)

From a helpful mental health team, to the worry and dread about the right type of carer, *not one with the wrong attitude*, resonated within the confidence of

Participants 09 ,13 and 19. They all clearly articulated an experience, an emotional connection and the consequences of fear's eroding effect on their confidences':

... you get confidence in the person you are with. They all know what they are doing, but some are more (.) efficient at it than others. Now, if you got someone that's really good at it, you got no fear whatsoever. You know they are there and they'll help if you get into problems. But you get the odd ones, that although they do it, you ain't got the same confidence in them. They don't have the same attitude as the other ones. (P09, starts line 7)

Another thing [that knocks your confidence apart from worrying about falling again] is, ... if you come into hospital, some of the staff, are really lovely and that makes such a big difference to your confidence. Like, for instance when night-time comes, you look and see what nurses are on you see. And then, there may be one where I think 'Oh my goodness, she's on tonight!'. She might be a bit quicker, you know, a bit stricter ... (P13, starts line 13)

I have more confidence at home than what I have here ... I don't know why that is. I don't know if it's some of the nurses that force me ... she come over and pulled me up out of the chair [to walk]. I thought 'Oh, why don't you leave me alone'. I thought, [...] I won't tell you what I thought about her. [laughs] ... they like to see you get on and they like to get on [but] you got to have enough confidence to do it. ... if you ain't got the confidence. You may as well give up. (P19, starts line 61)

Acknowledging this diversity of fear, this essential theme is therefore interpreted and described in Table 20.

Table 20: The dimension of fear.

The dimension of fear
<p>Fear (also referred to as dread, anxiety, fright, panic or worry) is tethered to the confidence for older people living with frailty. Whether triggered by an incapacitating fall, an illness such as delirium or, through the treatment or care received, fear can powerfully erode a person's inner confidence. This fear resides in the person's mind, playing psychological games. For some, they can speak to the confidence inside and try to bargain and rationalise with it, in some convincing way. These internal conversations attempt to overcome fear's ability to wear or tear away at the person's confidence. For others it completely disables their desires, leaving them helpless and hopeless, and for some completely mentally debilitated and depressed. Confidence is consumed by fear.</p>

The element of talking to oneself to address this confidence is illustrated in this extract from the guided existential enquiry of Participant 09:

Lived space: ...*There seemed a tension between her anxious and panicked moments at times of crisis when alone, and the existential, stepping outside herself to 'give herself a talking to' in an attempt to rally something from inside – her inner space – to get on and move on. (P09 – Analysis)*

This is drawn from the interview transcript:

... do you see your confidence has changed?

I think it has changed, I panic more than I used to. I do panic, I do panic, I must admit I do panic, and panicking does not help. It doesn't help, cos once you panic its finished. (P09, starts line 102)

How does panicking connect to your experience of confidence?

Erm, (...) I suppose ... as soon as somebody is there and you knew they are there, you stop panicking and you are alright. Now, if you got someone that's really good at it [walking alongside you with your frame], you got no fear whatsoever. I begin to panic a bit and I say, 'I can't do it. (P09, starts line 168)

Another example:

I just hope I get back my confidence, my confidence will come back ... I'm a bit frightened of doing it [walking] ... 'Yes, I know I can do it', but then, I am scared to do it (.) and that's where I have lost my confidence. (P02, starts line 68)

Sometimes I think I'm better just left to get on with it now, you know, 'You can do it, just get on with it' (.) right?. There's something, a little something, at the back [of my mind], a little bit of nervousness... (P02, starts line 131).

Essential theme three: The dimension of independence

For some, the idea of independence was a strong driver to tackle concerns with their confidence. For example, Participant 03's lived experience makes a connection to her independence through reflecting on her understanding of her frailty.

[Describing confidence...] That's basically - vulnerable

Vulnerable is an interesting word – what do you mean by it?

A situation that I thought I could deal with in the past, I find I'm not so good at dealing with it.

What do you understand by the term frailty?

[Frailty] means someone who has not much in the way of muscle power and generally, physically, they are weaker than they were when they were younger.

Do you see that in yourself?

Yes, to a certain extent, I'm eighty my next birthday. It's something I accept would happen – everyone does ... (P03, starts line 52)

... But you said it feels inevitable as you get older?

... I mean unless you have been a very physically active person you are bound to err, have that problem as you get older. I mean, there was a woman in the next bed in hospital to me, she was ninety-five. Then she played golf for years, that's bound to help her deal with any frailty. (P03, starts line 66)

Analysis of the incidental themes and interviews, identified that this essential theme strongly connects to independence (Figure 15).



Figure 15: Illustration of the dimension of independence and key words that emerged from the seventeen older peoples' interviews.

This essential theme is interpreted and presented in Table 21.

Table 21: The dimension of independence.

The dimension of independence
<p>The determination to be independent is a physical driver for confidence.</p> <p>Confidence's connection to physical functioning is important to maintain. The person's body and its physical strength is important in sustaining their independence and overcome the limitations the person living with frailty increasingly faces in later life. Confidence is often undermined or lost as a result of the physical effects of accident, injury or ailment. Quickly the person's ability to physically look after themselves, to self-care, can be affected. For some, a growing dependency appears to sit beside a fading confidence – an uncomfortable and sometimes painful companion. For others the desire to physically overcome a feeling of frailty, lays witness to a growing confidence.</p>

The determination of Participant 08 illustrates the capturing of one's confidence for independence, in their lived crusade to *get up and go*:

What does confidence mean to you, in your experience?

It means get up and go. You got to, you can't always rely on others, in here they are as good as gold – nothing is too much trouble. I've been treated like the Queen. But, you got to do something yourself. Not sit in a chair and say, 'I'm not going to do anything [you say] I AM GOING TO DO IT' [she shouts and laughs]

A lot of it comes from yourself?

You got to help yourself ... They say, 'You can do it my lovely, you're determined, you can do it' and I done it. And they see some difference in me ... that boost ... It helps you ... It encourages you and helps you ...
(P08, starts line 54)

It contrast Participant 04 indicates how confidence, when taken away by an ailment, can impact on self-care abilities.

Once I had those falls, I lost all my confidence, I just can't seem to manage anymore.

... what do you think it did inside [you,] to affect your confidence?

(.) I don't know (.) I can't explain it. (.) I just lose my ...(.)... I used to get up and go walking... I just don't know, I just don't know. I know I could do with some help. That's all I can tell you ...

... I definitely know I could do with some proper help ... doing washing ... Doing cleaning, yer, which I can't, I can't ... which soon as I get up and get going about, cor my bloody back, it's murder and I have to sit down, I can't do it. I ain't going to bother anymore. (P04, starts line 76)

Like the other essential themes, this met van Manen's *free imaginative variation* test (1990: 107). The conversations were rich in associating confidence with strength and weakness, with dependency and disabling limitations to physical health and well-being. Independence and its drive to have it are exposed in Participant 13 interview:

Well, confidence means to me, having first of all the equipment that is available so you have got it there, rather than struggle. Like in my case, I've had several horrendous falls, you know ... I have a dog and I go walking but, I find that my confidence has been knocked by these falls. So, when I'm walking I always keep my elbow crutch with me. Erm, but it takes your confidence as though, you're sort of walking along and I'm thinking 'I mustn't fall, I mustn't fall down' or anything like that. Sometimes when things like that happen you can say that knocks your confidence. (P13, starts line 6).

This extract from Participant 13's guided existential inquiry of the lived body or their corporality, exposes the connection between independence and confidence:

Lived body: The physicality of walking and the independence associated with this need to walk – the internal talking to herself, ‘I mustn’t fall’ (line 11), comes through as a significant element affecting this participant’s confidence in the interview.... (P13, Guided existential enquiry)

From the transcript of Participant 22, this physical independence connection to confidence is described in tangible terms:

If I could walk across the ward. I cannot bear being stuck here in bed, it’s destroyed it [my confidence]. (P22, starts line 84)

Many independence references in the transcripts also link to the final, fourth, essential theme – the dimension of control.

Essential theme four: The dimension of control

Control emerged much later in the phenomenological enquiry’s analysis. Data from the phenomenological enquiry clearly reveals the dimension of control, reflecting strong connections to confidence experiences in respect to resilience and vulnerability (Figure 16).

The description of this essential theme emerged from the deeper analysis exploring different themes’ absence effect on the notion of lived experience of confidence. Levels of control were noticeable with all participants in the phenomenological analysis. There were intrinsic and extrinsic factors to this control, positive and negative. The control of confidence was seen as positively by a number of participants, but many experienced how unreachable or unachievable this essential confidence connection can be. The dimension of control is interpreted and described in Table 22.

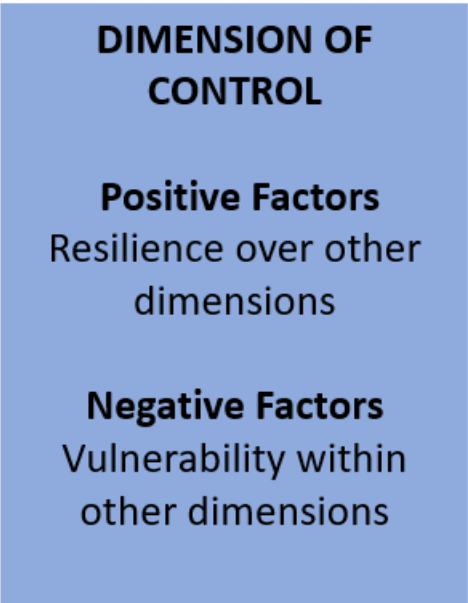


Figure 16: Illustration of the dimension of control and key words that emerged from the seventeen older peoples’ interviews.

Table 22: The dimension of control.

The dimension of control
<p>The control an individual has over their confidence is variable. Some older people living with frailty have a natural belief in the control they have over their confidence. These people often refer to their experience of confidence over their life-course, a confidence that has been shaped, by themselves, but often by others. This confidence carries forward into older age. However, as frailty becomes recognisable in their bodies and minds, the vulnerability of control over their confidence may falter and they become hesitant. This vulnerability is influenced by a reliance on other social, psychological and physical factors. For example, social connections (family, friends, healthcare professionals, neighbours or carers) in older peoples’ lives can be control givers or control</p>

removers. A strong connection to a social group, to family and friends, can liberate a person's control over a vulnerable confidence. The opposite sees loneliness and isolation limiting control and removing their resilience and then their confidence. Mental or psychological control over matters of confidence help some people, but mental fragility removes this control quickly and can rapidly take confidence away from their grasp. Regarding physical factors and independence, strength building and activities like goal-planning and target setting to regain mobility and self-care capabilities help gives control back. For others their control over confidence in physical matters will always be a struggle, overwhelmingly influenced by complex health problems, impairments and disabilities. There is a constant tension between the person's internal control over their confidence and external control or controlling factors that affect their inner confidence.

This description demonstrates the multidimensional and multifactorial aspects of control. This fourth essential theme interconnects with the previously described dimensions of confidence that must be present for confidence to exist in these lifeworld narratives. For example, you cannot have the *interpersonal connections* of the social paradigm without them exerting a level of control over that older person's confidence. The same exists for the other dimensions. Time and time again through reading and rereading the transcripts, the analysis, and the descriptions of the other three dimensions, you see control taking a fundamental and essential presence.

The dimension of independence description (Table 21) states:

The person's body and its physical strength is important in sustaining their independence and overcoming the limitations the person living with frailty increasingly faces in later life. (Excerpt from Table 21)

Participant 18, for example, talked about needing help to support him when he returned home. He reflects on having to give away some level of control in this process (linked to independent living limitations), as he goes on to recall a different, more confident time in his later life:

Well I've been very lucky. I was in fishing by myself until gone my eighties ... Mackerel catching, I had a few falls in the harbour, and I thought it was time to pack up [laughs] and there is never any help when you fall in. It's funny that.

What's it like to fall and not have help?

I'm not afraid of that, as I can still swim. (P18, starts line 38)

His confident statement, at the end, demonstrated a resilience that he lived with, as he was a fisherman. In contrast, when confidence was taken away through illness (delirium) it left the person – *feeling vulnerable* (P11, line 236) and out of control. This participant goes on to describe their experience of being in this position and being unable to communicate:

[confidence means] to do what you want to do, the confidence to say what you want to say. Erm (...)

... because nobody was taking notice of what I was trying to say and I was not able to get over to them what I meant [a result of the delirium]. Erm, that's where I lost confidence, erm, because not being able to, erm, communicate, its bad. That's when I lost my confidence then. (P11, starts line 20)

The social connections to home and family can give a feeling of control and confidence. When in hospital, Participant 01 spoke of the worry and fear they had when thinking about returning home from hospital. The control or out-of-control dimensions were clearly visible:

...describe what confidence means to you?

Well, to come home from hospital and to be in your own home and everything. (P01, starts line 18)

This participant stated her mood was low, feeling:

Low in thought, you know, I think, am I going home or what's going to happen to me. (P01, starts line 33)

This older participant's carer was also interviewed. The carer usefully added context to this confidence related comment, in particular about her cared for's worry when in hospital, thinking she may never get home.

... her biggest worry... while she was in there ... 'Am I ever going to come home?' ... you know when they are talking about antibiotics, and she did have a big water infection, then they were x-raying, scanning, pushing needles into her and she's lying in her bed thinking, 'What aren't they telling me?', 'Am I going home?'. I think towards the end of her stay they were sort of interviewing her. 'How many steps have you got?', 'Do you need this?', 'Do you need that?'. I think she started thinking more (.) relief, 'Oh I might be coming home', 'They're talking about me coming home'. But when she first went in, ... home wasn't mentioned much and that was her biggest confidence dip. ... 'Am I going to be spending my last days in a hospital ward?', and that was a real, a huge fright for her I think. (Carer Participant 01, starts line 287)

She did go home, but her worrying did not stop:

I was glad to be home ... I started mobbing [mobilising] around a bit more (.) but scared that first night. I was afraid I would fall again. (P01, starts line 125)

This illustrates that the fear of falls was never too far away. The sense of being out of control and its consequential negative impact on confidence was illuminated by her carer again.

... sometimes they don't realise quite how deaf she is and I think she missed out on a lot of information. And without that information you wouldn't feel confident. You know, she's, 'Oh they stick needles in me all the time, but I don't know what for?'. So I would find out, 'Oh yer, ... they are giving you a blood test because of this, this and this.' She would be 'Oh, okay'. And I think a lot of the confidence she lacked was because she didn't really know what was going on. (Carer Participant 01, starts line 105)

Despite this experience coming from a carer's description of confidence and not that of a lived experience of the older participant, it provided a rich context to interpret the more limited words of the oldest and frailest participant in this study.

Another example of the interplay of control with family (she calls them visitors) and confidence came from Participant 13:

Well, I think it's very important that you try and keep your confidence, because (.) particularly if you've, say been in hospital and your visitors come and they say, 'When you come home you are not going to do this and you are going to get rid of that'. I don't like that. I want to go home and look and see, you know, why I fell and, by not concentrating on what I was doing and pick up my life as it was. I don't want to alter everything because I'm older and I had a fall, or several falls. ... I don't like people saying, (.) I take advice, but ... 'don't really want to do that', but 'I'd better go along with that', so I think you have got to have the confidence to say, 'No, thank you very much, but this is what I want to do, not that'. It's no good someone saying to you, 'If you fall', and they say, 'Were you going out with the dog – Oh, you want to be careful, what happens if you fall?'. Well that knocks your confidence right down. You have got to be quite strong to say, 'Ignore that'. That's the wrong thing people should

say. They could say, 'Be careful, don't fall', but not, 'I wouldn't do that you know, what happened last time?'. (P13, starts line 231)

Her strength to say to herself *ignore it*, appears to be connected to a resilience she has inside, in taking control of her independence. The interconnectedness with the other dimension is always complex and interlocked.

This concludes this section. The four essential themes from the older people's cohort of participants have been presented and now, the dimensions are evaluated against the views of others, to search for connections and contradictions, thereby contributing to the study's credibility (Lincoln and Guba, 1985).

Others' views on the essential themes: the four dimensions

This section reports the findings of the analyses of carers' and healthcare professionals' views from their interviews, and participant checking on the essential themes. The interviews focused on eliciting the experience of confidence witnessed in those being cared for.

Carers' views

Reviewing carers' transcripts and listening to digital recordings, the four essential themes identified from the experiences of the older people continue to have resonance. Confidence and the social connections with others appear in all conversations with carers and healthcare professionals. This excerpt, from an interview with a carer, illustrates how the dimensions merged and are layered in their account of experiencing confidence in their cared for:

...she's was very dubious about the [homecare] carers and I think that showed her lack of confidence because she had to give herself up to these strangers. She had never had strangers in and out of the house before ... I think that's a big step. She's had to find confidence in them as well. She's had to let them in and I think that's one thing I've noticed, that's she's getting more confident with, in the carers, she will let them, you know, she's getting more reliant on them... (Carer Participant 01, starts line 256)

This shows social connections and control interplaying with each other through growing physical dependency.

Anxiety is an attribute within the domain of fear, linked to hesitancy and worry.

Another carer, talking about his wife's return home following a stroke, reflects:

... she is still reluctant to do many things, due to her confidence. For example, going out the house. I think her anxiety holds her back in this regard. She may see problems which may not exist. (Carer Participant 02, starts line 25)

For this carer, confidence's dimension of social connections is evident:

...we are very social people and have a good network of people who have been visiting us, but before my wife's loss of mobility and loss of confidence we used to get out a lot. For example, we belong to four luncheon clubs locally. Getting out much less these last few months has impacted on us. ... My wife still worries about this though, but recognises too, that being out socially does increase her confidence. (Carer Participant 02, starts line 41)

And here, a link between fearfulness and how losing control impacts on confidence:

It was particularly seen in her walking. Her loss of mobility affected her confidence and she was afraid to damage her leg [my wife has diabetes and a history of chronic leg ulcers, so any damage to her legs takes a long time to heal]. (Carer Participant 02, starts line 22)

Although limited by the small number of carers interviewed, these findings suggest quite strongly that there is a perceptive connection between the carers experience of their cared for's confidence and how they strongly link to the four essential themes.

Healthcare professionals' views drawn from their interviews

Following an exploration of confidence's presence in the healthcare professionals' interviews, the essential themes that emerged from analyses of older people's lived experience of confidence were also found in these data. Healthcare Professionals (HCP) appeared to recognise and acknowledge this view of confidence with older people. They all sensed a confidence concern in conversations, often without the confidence word being spoken. For example:

... they don't often express it. ... you can pick it [up], you often see they look unconfident, they look scared, they look very unhappy in their environment, ... you almost observe them, they worry a lot more. They are not very happy about [their] walking, 'I'm worried about it', 'Not coping', ... 'I'm scared of falling', 'I'm scared'. (HCP02, starts line 86)

And:

... they might appear anxious when you talk about going home, like make up lots of reasons or excuses why they can't go home. ... you are trying to unpick what is it really that they don't want to go home to, what are they worried about and usually this does come down to confidence. If they have had a long stay in hospital, they are anxious about leaving, they don't know whether they could look after themselves, they are not confident ... (HCP01, starts line 31)

Healthcare professionals recognised confidence as related to the dimensions of confidence exposed by the essential themes. This extract illustrates the

dimension of social connections' relationship to confidence, beyond initial first impressions:

... one lady who was in our side room, who did not want to go home. She used lots of delaying tactics, 'I can't walk to the bathroom', 'I don't want to get up', 'I don't want to sit out for lunch'. But actually, when I sat down and talked to her and asked her what she does at home. She said, 'Well I don't go out and no one really visits. Only my son really, once a week'. I said, 'How does that make you feel?', she said 'Oh, awfully lonely, it makes me worried, because what if I fall on the floor, what if it I can't get help?'. (HCP03, starts line 61)

Loneliness and isolation from others and the absence of social connections to family and friends in a patient's life were all identified within the healthcare professional's interview data. Healthcare Professional 04 describes a confidence situation she recognised in which these connections were prominent:

...a little lady with dementia whose husband recently passed away. He was her main carer. She came to hospital as a social admission, ... very low in mood. Didn't come out of the side room she was in. Wouldn't wash, wouldn't dress, wouldn't transfer out of bed. Sort of curled up in a ball and given up. The bereavement counsellor came down and they talked about things. The vicar came down to see her, just different things, different processes. She got out [of bed]. She was in the dayroom, watching television with others, interacting and, yeh, it's quite nice. Different input from different people. (HCP04, starts line 64)

The impact of social connections on a person's confidence is clearly recognised by this healthcare professional. But the loss of a loved one and a carer which influenced the initial retreat and reluctance to live, in many ways, by just giving up, appeared entwined in the concept of confidence from that extract.

Finally, confidence in the connection, or social bond, to others, was commonly heard in older people's interviews. This is reflected in the confidence promoting aspect of professional presence:

... 'I cannot do it' was the phrase she would often say. You would be with her to provide that confidence that you will be ok, she could do it.
(HCP02, starts line 319)

If you exude confidence, you exude confident patients ... and they will do anything you ask them to do. But, they're very [...] they are astute at picking up fear of people, staff not feeling confident themselves. ... You have to teach them to be confident, because if they go in showing some fear, these people with a lifetime of experience, they can smell that fear, they can sense it [laughs]. 'You're not confident, therefore, I'm not feeling brilliant and I'm not getting up with you'. (HCP02, starts line 355)

Within confidence's dimension of fear, healthcare professionals connected fear to influencing physical factors:

... patients' always say, 'I'm afraid I'm going to fall'. And falling seems to be a major fear in people with frailty because, I think it sets them back ...
(HCP03, starts line 21)

... she was worried and not confident on her feet, ... (HCP01, starts line 89)

... they cannot get out of bed, they cannot move, they are fearful, they are scared, they are weak, they are wobbly. ... we can make people better and get them back on their feet and get them, you know, they will be often scared to stand to up, scared to mobilise, they are not confident they are going to keep their balance. (HCP02, starts line 163)

But fear transcends these physical aspects, as does the description of the essential theme (Table 20). This is reflected by Healthcare Professional 03 who

summarised this multidimensional aspect of fear, which can be present in multiple dimensions:

... [referencing fear of falling] I think the other fear for people is that confidence impacts upon fear of losing their home, fear of losing their independence, fear of losing their social networks, ... (HCP03, starts line 166)

Here fear relates to the domain of social connections and control:

...a patient will say they are not confident and it's a fear. A fear of going home by themselves, of falling, of no one finding them, that's more a fear than confidence. So, if you can get the fear under control then confidence comes back. (HCP04, starts line 130)

These extracts also illustrate the interconnectivity of the essential themes, across the paradigms of social, psychological and physical and how they interrelate with the fourth paradigm, that of the control the individual feels they have.

A final aspect of confidence emerged from the healthcare professionals' interviews. This related to how the research study itself focused attention on older people's confidence and this affected them and the older people who participated. For example, Healthcare Professional 04 reported:

A couple [of participants] have said, that once they had spoken to you, they kind of understood more about the difference between fear and confidence and it made them decide, 'I am not fearful' or, 'I am not confident'. So, it makes them explore it a little more. Some thought by talking to you they actually thought, 'This is not a confidence thing, this is fear' and have spoken with relevant professionals, the [Occupational Therapist and Physiotherapist], they have got a grasp of what they were fearful of and gone home with a much more positive outlook. (HCP04, starts line 142)

Healthcare Professional 04 reflections propose the use of more focused and targeted questions in the future as a result of participation:

... I think if we ask, 'What are you not confident in?' we might get a more direct answer, so we can focus on something specifically. (HCP04, starts line 274)

When someone says, 'I'm not going to manage', ... 'I don't feel I'm well enough to go home'. It's not, 'I've not got this', it's not, 'I can't do shopping'. It's, 'I'm not going to manage'. So, it's 'What are [you] not confident in?', [and] what's missing [is] what we do to fill that gap to get that person home safely. (HCP04, starts line 286)

Researcher's Reflections

Overall, these interviews confirmed and, in part, go quite a way to consolidate the dimensions of confidence by creating a new conceptual framework. The synergy is clear; those interacting through care with older people with confidence concerns can recognise them and relate to confidence as defined by these broad dimensions. It was somewhat surprising that confidence could so easily be linked to one, and often two of the dimensions by the healthcare professionals. It was also rewarding that they appeared to see value in exploring further the practical application of this new and unique understanding. The final point, made by healthcare professional participant 04, informed by the participant's feelings, indicated that a confidence related conversation has the potential to offer a simple and practical opportunity to move this new knowledge into practice.

Participant checking of the essential themes

Older people have been directly involved in this research from its outset and so it was important to continue this and give them the opportunity to comment on the interpretations made through these analyses of the phenomenological data.

Older peoples' feedback

Despite only three responses being received, two found the language used to describe the essential themes difficult to understand. However, the third participant to respond provided quite comprehensive feedback. Responding to the first theme, that of social connections to others, she wrote *obviously the impact of others helps with confidence* (P03, response to follow-up communication). To the second essential theme of fear, she wrote: *Again something I would think to be very obvious. If you had a fall you will worry about falling again etc.* (P03, response to follow-up communication).

The third essential theme, relating to physical independence being the driver of confidence, she wrote: *Confidence is the driver for physical independence* (P03, response to follow-up communication).

Control of confidence was the fourth theme, here the comment was: *Can be achieved with help from others* (P03, response to follow-up communication).

This comment resonating back to the first theme. And finally, when asked to provide any other comments. Participant 03 wrote: *Support and encouragement from family and others is very helpful and can make a big difference* (P03, Response to follow-up communication).

Carers' feedback

No carers responded to the opportunity to give feedback on the findings their interviews contributed to.

Healthcare professionals' feedback

One person from the healthcare professional cohort responded. Healthcare professional 02 stated:

I really like what you have produced. The presentation and pictures are beautifully presented and well written. Poetic and emotive. (HCP02, feedback correspondence)

Commenting on the themes they wrote:

I largely agree with the themes and the points being made. It makes sense. (HCP02, feedback correspondence)

Making a personal connection to the themes they stated:

You have described well some of the thoughts I have had when interacting with people with frailty. (HCP02, feedback correspondence)

Commenting on the usefulness of the illustration of the four dimensions (Figure 12) to support practitioner understanding of the dimensional connections to confidence, they wrote:

I like the concept of the diagram. (HCP02, feedback correspondence)

The responses from participants were largely positive, however it was very disappointing that so few people were able to contribute to this important confirmatory stage of the study. This impact of this will be explored further in the discussion chapter.

Summary

This chapter has presented analyses and findings from the third stage of this thesis's research study (Figure 10): the phenomenological enquiry. Large amounts of rich data were analysed and interpreted, enabling new and unique insights to be gained through the voices of the older people. Furthermore, the reflexive approach taken has served to provide the reader with details that help to reveal how four unique essential themes emerged. These themes and the discovery process drawn from the lived experiences of older people living with frailty, have generated evocative narratives that explain and underline these dimensions of confidence. This new understanding of confidence adds to the body of knowledge and is developed further in the next chapter, where these findings are considered in conjunction with those from the other phases of this study.

CHAPTER 7:

METHOD TRINGULATION: FORMULATING THE FINAL CONCEPT

Introduction

This chapter concentrates on method triangulation, which formed the fourth and final stage of the interpretivist study (Figure 17).

		Stages	Study Description	Methodology		
Doctoral Study		Systematic review	Meta-aggregation of contemporary qualitative evidence	JB1 Systematic Review	Knowledge to Action Framework	Knowledge Creation
		Primary concept development	Concept development from contemporary qualitative literature	Walker and Avant method		
		Phenomenological enquiry	Interpretive phenomenology (participant study)	van Manen's methodological structure for human science research		
		Study's findings review	Final concept production	Method Triangulation		

Figure 17: Illustration of the four stage study design highlighting the study's final findings review stage.

An overview of the methodological approach adopted is described and presented against the published literature that has shaped and guided this process. This final analytical stage utilises the findings from the systematic

review, the concept analysis and those from the phenomenological enquiry to make a final declaration on the concept of confidence.

A method to reconstruct the final concept

This section presents the methodological approach used to synthesise all the qualitative studies' findings to formulate the final product, the end-point of new knowledge generation (Graham et al., 2006). In this case, a revised concept of confidence, after embracing the detailed findings of the phenomenological enquiry.

Smith (2016: 3) cites Rothberg (1991) who identifies *three main intentions of modern human science: description, interpretation and the reconstruction of meaning*. The goals of human science are therefore: to describe the phenomena from the perspective of individuals or groups; interpret an understanding of the phenomena; and finally, to reconstruct the meaning to bring a sense of new knowing.

This sections also positions van Manen's sixth step of the methodological approach to human science (*balancing the research context by considering parts and whole* (van Manen, 1990: 33)) within the wider study. Therefore, this final stage of the study adopts an approach to maintaining the wider study's overall human science stance: to contextually *describe* the outcomes (phenomena) from three unique qualitative research studies; to identify a methodological approach to support *interpretation*; and to finally *reconstruct* a robust conceptual framework of the phenomena to translate to clinical practice (Rothberg, 1991). The approach adopted to do this is method triangulation.

Thus the methodological triangulation presents an important opportunity to pause, to take a step back and look around to fully review the quality and contextual elements of the analysis so far, and then to understand how they may contribute to the whole; to the complete meaning and understanding of confidence.

Method triangulation: the evidence base

Methodological or method triangulation involves using multiple data collection methods relating to the same phenomenon (Polit and Beck, 2012). A triangulation approach to such data is commonly used in qualitative research studies (Carter et al., 2014, Farmer et al., 2006). Within-method, refers to all triangulated studies existing in the qualitative paradigm, whereas across-method, triangulates qualitative with quantitative data sources (Bekhet and Zauszniewski, 2012) or more commonly referred to as mixed-method (Risjord et al., 2002). Bekhet and Zauszniewski (2012) report multiple studies positively using methodological triangulation to strengthen and confirm findings. They state that the review of more comprehensive data increases study validity as it contributes to enhancing understanding of the studied phenomena.

Heesen et al. (2016) and Risjord et al. (2001) write of methodological triangulation aiming to yield an answer that strongly confirms a singularity. If the same answer is derived from multiple methods, then the answer is confirmed more strongly than if arrived at from just one method. Farmer et al. (2006) recognise the approach's strength, which is to increase the study findings' credibility and dependability. The literature is light on practical means of conducting methodological triangulation, much focused on the technicalities of

mixed-method triangulation. This dearth of literature was recognised by Farmer et al. (2006); their study critically explores this and illustrated the conduct of a ‘qualitative focused within-methods’ triangulation. They advocate strongly for well-articulated procedural steps of the iterative approach adopted to be documented and reported (Farmer et al., 2006).

Mathison (1988) cites Denzin (1978) who states three possible outcomes of using the approaches to triangulation: convergence, where findings result in a single proposition about the phenomena; inconsistency, where data findings do not confirm a single proposition; and contradiction, where findings from the multiple methodological approaches to the same phenomena oppose each other. Mathison (1988: 17) states that when convergence is not found, then the researchers need to *make sense of what we find*. Then goes on to comment:

that this moves the focus on triangulation away from a technological solution for ensuring validity and places the responsibility with the researcher for the construction of plausible explanation about the phenomena being studied (Mathison, 1988: 17).

This section now brings together key findings from the three interconnected studies before describing the analysis:

- The systematic review (reported in Chapter 3) found significant shortcoming in the body of qualitative literature appraised, relating to voiced expressions of confidence from older people living with frailty.
- This grew marginally as the concept analysis was developed (reported in Chapter 4), finding new voices as a greater breadth of literature was drawn upon to inform this analysis.

- The final phenomenological enquiry sought and progressed to explore the rich lived life worlds of seventeen older people with frailty who significantly augmented the research literature with their voices. This unique and original contribution to the existing evidence base became a confirmatory objective of this thesis.

Findings from these first three stages of the study are summarised in Table 23 to aid reference of the appraisal of this next section.

Table 23: Summary of findings from stage's one, two and three of this study.

The Systematic Review:

Three categories were identified:

Self-belief - An emotional drive to achieve an outcome or a self-belief in oneself to achieve a goal.

Independence - A functional or emotional state where 'confidence' can be seen to directly enhance or erode the state.

Social connectedness - The individual's connection (or dis-connection) with a social group in the community e.g. friends and family, or to a therapeutic / activity group as a program participant

These categories were synthesised into a single finding:

Vulnerability - a fragile state of well-being that is exposed to the conflicting tensions between physical, emotional and social factors capable of enhancing or eroding this state.

The Concept Analysis:

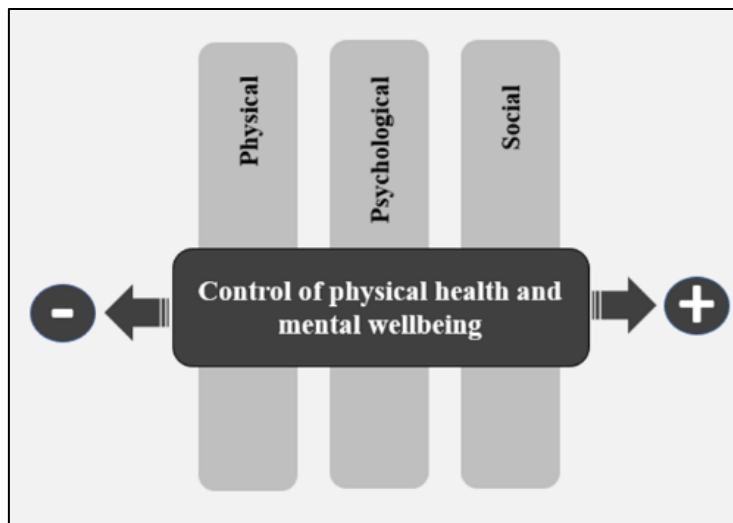
The Model Case from the concept analysis:

The concept of confidence is built from a range of attributes that fall within one of three domains – a physical, a psychological and a social domain; all intrinsically connected to the older person. Individually these three domains will differ between individuals, and day-to-day will differ within the

continued

person. The concept is centred on personal control, influenced by internal and external factors to the person. These factors can be enabling factors

(positive factors) or dis-enabling factors (or negative factors) to the persons physical health and mental well-being.

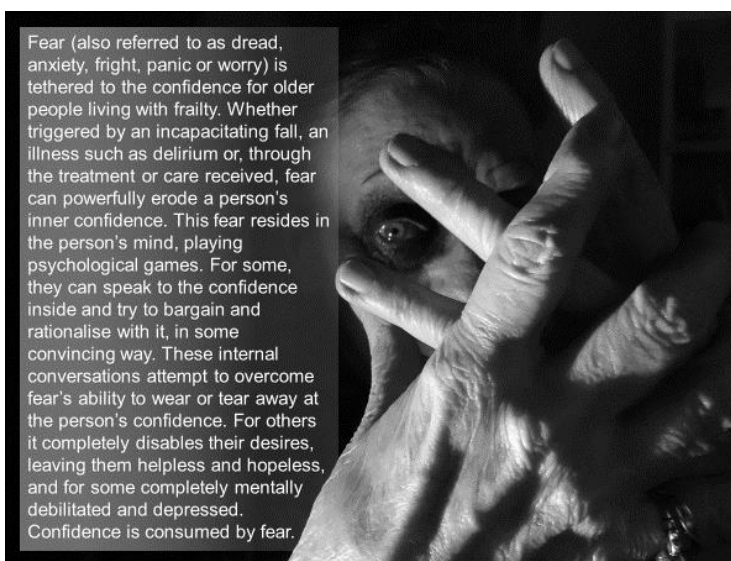


The Phenomenological Enquiry:

The four dimensions of confidence have been presented in the first section of this chapter and detailed in Tables: 15, 16, 17, 18.

- The dimension of social connections
- The dimension of fear
- The dimension of independence
- The dimension of control

Presented with a title and narrative descriptor. Later set against photographs to enhance their evocative impact (Appendix 8)



Method triangulation: application in practice

Bekhet and Zauszniewski (2012) reinforce the importance placed on maintaining focus on the original research question when conducting method triangulation. This is also echoed in van Manen's fifth element of the human science methodological structure (Table 9): maintaining a strong and oriented relation to the phenomenon (van Manen, 1990: 31-34). Each independent study stage committed to searching out the voice of older people in order to answer the overarching research question. Over the three studies, a growing body of data was collected to inform a continuous re-examination of the response to the original question.

Judging the weight of evidence

Johnstone (2007), who explored the dilemmas of data triangulation, turned to Law for an analogy to support researchers grappling with such questions as: *How might I decide which evidence to accept? or Which evidence to regard as insignificant?* and *Is all data equal?* (Johnstone, 2007: 27-28). She argued that central to resolving such issues are transparency and the researcher's reflexive approach in presenting the case. Researchers, therefore, must judge the weight of evidence presented, its credibility and strength, as in a court of justice.

Johnstone suggested that if two sources of evidence are triangulated to corroborate the facts, then the judgement is valued, referencing the legal premise that, on the balance of probabilities, there is a truth beyond reasonable doubt (Johnstone, 2007). Heale and Forbes (2013) highlight the criticism of in-method triangulation, noting that researchers often assume data from distinct research methods are comparable and often they are not of equal weight.

Consequently, it is important that the credibility and strength of evidence of each of the three study's findings are assessed.

The aim of this research was to discover meaning and understanding of confidence from the lived experiences of older people living with frailty. Voices of older people were distinctly lacking in the literature, as evidenced by the findings from the systematic review's search. Thus this phase of the research made the weakest contribution in that very few voices of older people were included in the meta-aggregation of categories that led to a final synthesised finding of *vulnerability*. This weight of evidence was strengthened by the concept analysis, where the literature reviewed was from a broader perspective. More voices were found and central to this phase of the research was the development of a primary concept of confidence, which was supported by the model case and other cases, illustrating lived ideas of what confidence is (and is not) from the perspective of an older person living with frailty (based on the evidence reviewed). The final study's findings were weighted with the highest level of credibility and strength of evidence as the phenomenological enquiry gave the richest and deepest lived world experiences of confidence. That phase truly added a unique and original contribution to the existing evidence base and brought to life the challenges faced by older people as they struggle with frailty. Therefore, it has been possible to roll the findings of one study onto the next, to enable an evolution of conceptual ideas. Findings from the systematic review were included in the literature review that supported the concept analysis. The systematic review's findings and those of the concept analysis were also present in the interview phase of the phenomenological enquiry (forming line of

enquiry prompts where needed), and so the strength of evidence grew. It is this tiered level of evidential credibility and strength that has been accounted for in this application of method triangulation.

Triangulation of the three dimensions of confidence: physical, social and psychological

The researcher sketched and illustrated his early ideas on the connection between the interconnectivity of the studies' findings (see Figure 18). Common across all three studies was references to the three domains, social, psychological and physical. These shall be explored first in the application of method triangulation, before reviewing the cross-cutting dimension of control.

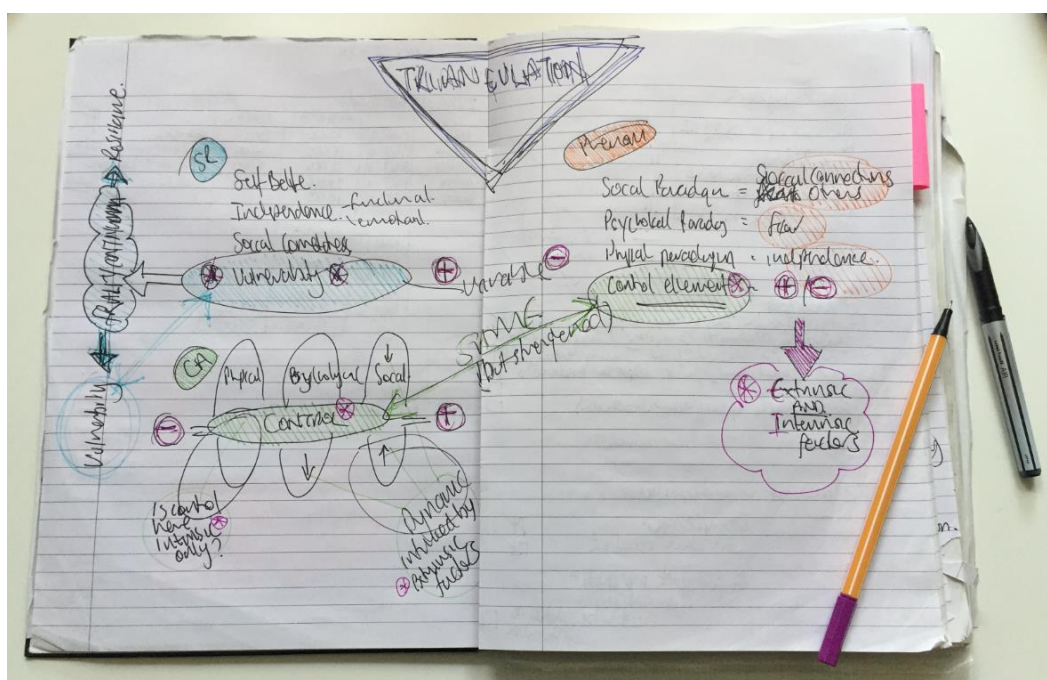


Figure 18: Photograph of the researcher's notebook showing an illustration of method triangulation idea developments

Across these domains consideration was given to the methods' notions of convergence, inconsistency or contradiction (Mathison, 1988) when interpreting any interrelated associations within the three dimensions. These dimensions share commonality with frailty models, the broader tradition of geriatric medicine, and of gerontological nursing, practiced thorough the comprehensive geriatric assessment method (Ellis et al., 2017). However, the weight of evidence, as described above, is an important consideration to value in these dimensional evaluations. At a high level, method triangulation identifies a significantly strong convergence (Mathison, 1988) with the findings connected to two of the three paradigms – the confidence connection with social connectedness and with physical independence. This is indifferent to any weight placed on them individually at this time.

Social connectedness from the systematic review (the weakest level of confirmable evidence), particularly the connections and disconnections with social groups in the community, associates strongly with the dimension of social connections to others, that arose from the phenomenological enquiry (the strongest level of confirmable evidence). Qualifying this further for transparency, the systematic review's contextual description of the criteria *social connectedness* states in full that confidence is connected to:

The individual's connection [or dis-connection] with a social group in the community e.g. friends and family, or to a therapeutic / activity group as a program participant goal. (Underwood et al., 2017: 1327)

The researcher, in evaluating the weight of evidence, believes this is the stronger of the three categories from the review. The phenomenological enquiry's social paradigm descriptor of the social connection to others states:

This interpersonal connection is relational, it is a social association between them, the significant other in their life and then directly to their confidence. This dimension takes on countless forms and characters. (Table 15).

It illustrates the positive and negative effect of others:

... these social bonds, these personal, social connections to confidence can be strong or very fragile. In strength the connection with family, friendship and companionship gives confidence, hope and optimism. If this bond to others is broken, either permanently or temporarily; through loss of a spouse or abandonment of friends, or to the fleeting trust held in the carers supporting them, this broken connection leaves a person holding on to a frail confidence; a vulnerable confidence. (Table 15).

These social connections are strong, or strongly desired, as are those within the emergent concept analysis of confidence (Underwood et al., 2020). Here, recognising the importance of social connectedness to confidence, the model case acknowledges an essential element reflected in the literature; the importance of getting out to *social activity events in the community and meeting others* (Table 8). The borderline case acknowledges this important element too, but in the case of Mr. Q., his cognitive impairment *restricts his social interaction with others* (Table 8), differentiating his case from the model case.

The conclusions and findings related to social connections from each of the three studies were read and reread in order to recognise a high level of connectivity between them. This supported strength in conviction when recommending *convergence* (Mathison, 1988) across this dimension.

Convergence was further reinforced by reflecting on the sub-level attributes from the concept analysis regarding social connections to confidence: *isolating; engagement with others; connected; community focused; family concern*

related; orientated to classes, groups, and positive involvement (Underwood et al., 2020: 745).

The conclusion therefore is that there is strong convergence across this social connections to confidence domain.

The focus now turns to the physical dimension of confidence. *Functional independence* from the systematic review correlates directly to *independence* that emerged from the lived experience enquiry. This suggests convergence is present, accepting the weaker contribution of evidence from the systematic reviews findings. The systematic review states independence as:

A functional or emotional state where 'confidence' can be seen to directly enhance or erode the state (Underwood et al., 2017: 1327).

Within the phenomenological enquiry, physical independence was seen to give energy to confidence, which was connected to the individual's determination to be independent. The accompanying descriptor captures the importance older people living with frailty place on maintaining this physical ability and, consequently, their confidence. However, its fragility was also recognised; *Confidence is often undermined or lost as a result of the physical effects of accident, injury or ailment*, seeing confidence fading (Table 21).

This aspect of independence within the concept of confidence acknowledges the interplay of confidence's *enhancing* and *maintaining* elements sitting beside the eroding and fading ones. Within the concept analysis (where evidence is balanced and judged at a moderately high level), independence appears as a

defining attribute within the context of *independence growing*. It sits within a range of other physical attributes including: *falls associated, strength gaining, activity based, mobility reducing, poor balance specific and function losing impacts* (Underwood et al., 2020: 744). Here again, a mixture of positive and negative attributes are connected to independence, which reinforced the researcher's assessment of a positive convergence from these methodological findings (Mathison, 1988).

As a result, the conclusion here is that there is strong convergence across this physical independence connection to confidence domain.

Looking next to the psychological dimension of fear, there is weaker methodological triangulation convergence to define confidence across all three studies. Syntheses from the systematic review (again, judged reflecting the weakest evidence to influence triangulation) presented belief or *self-belief* as sitting within a psychological domain (Underwood et al., 2017: 1327). However, this idea of self-belief does not relate to the psychological dimension of *fear* from the lived experience of confidence from the phenomenological enquiry (the strongest evidence being triangulated). Therefore, this demonstrates clear *inconsistency*, if not contradiction, following method triangulation (Mathison, 1988).

In analysing these data further to understand more of this inconsistency and openly report the conflict, it is important to recognise more complex constructs interacting here. For example, self-belief's emotional drive, to achieve an outcome or goal, relates more to confidence's physical independence drive from the phenomenological enquiry. This confidence-related notion sits on a

psychological / physical domain (emotional drive / physical independence). It is possible that, the limitations of the systematic reviews finding, based on only eight narrative examples of expressed confidence may have influenced this conflicting interdependent psychological domain. Equally, the systematic review's *independence* connection to an *emotional state* could have easily fallen within a psychological domain of confidence too: *a functional or emotional state where confidence can be seen to directly enhance or erode the state* (Underwood et al., 2017: 1327). The systematic review's category findings appear now to be more interchangeable than concrete due to the evidence weighting.

Thus, it is important to find that fear is not present following method triangulation and, therefore, should be declared inconsistent. This fear dimension does, however, draw much greater synergetic strength from the concept analysis findings. This is strengthened by the wider review of the literature, which found a body of evidence around fear, particularly the fear of falling. This fear factor was influential in the development of the model, borderline and related cases that assist describing what confidence is and is not and, of note, support practitioners' in understanding confidence. All case descriptions had a fear of falling aspect within the circumstance of the case (Table 8).

The phenomenological enquiry brought the psychological dimension to life by describing a broader fear factor related to confidence. The strength of evidence, through the multiple voices of older people, all relating to an essential theme of fear, required the reappraisal of this method triangulation outcome. There was

now good evidence to suggest some level of convergence for this psychological domain, reflecting the important contribution that this aspect of the research makes to existing knowledge. The conclusion, therefore, is that there is a reasonable level of convergence across this fear-connected domain of confidence.

The final dimension of confidence is control and this is explored next.

The unique dimension of control

There is a strong commonality or convergence (Mathison, 1988), between the concept analysis element of *control* and that exposed in the lifeworld experiences of older people from the phenomenological study. In many ways the additional data from the phenomenological enquiry add significant new depths of understanding. Such richer detail moves beneath the simple positive and negative influencing factors of control.

Some older people living with frailty have a natural belief in the control they have over their confidence. ... For others their control over confidence will always be a struggle, overwhelmingly influenced by complex health problems, impairments and disabilities (Table 18).

The *control of physical and mental wellbeing* elements from the concept analysis' findings (Underwood et al., 2020) emerged from several contemporary studies referencing control associated perspectives within their text. Words such as *participation, engagement, independence, self-belief, knowledge, skills and security* become defining attributes (Claassens et al., 2014, Parry et al., 2001, Wallin et al., 2007, Yardley et al., 2006, Underwood et al., 2015). These attributes are all positive and are mirrored by those from the phenomenological enquiry, with many present in the narrative supporting the dimension of control:

... connection to a social group, to family and friends, independence, strength building and activities like goal-planning and target setting to regain mobility and self-care capabilities (Table 18).

Equally, negative characteristics, drawn from life experiences of older people are present too and reflect those confidence-removing attributes cited in the concept analysis study: loneliness, isolation and mental fragility (Beesley et al., 2011, McDougall and Balyer, 1998, Parry et al., 2016).

It is clear that these descriptions are connected to and could be describing the intrinsic and extrinsic nature of confidence's dimension of control. The systematic review did not make any direct connection to control (as in the previous dimension), rather the metasynthesised finding of the review was vulnerability. This vulnerability in confidence was seen:

as a fragile state of well-being open to the conflicting tension between physical, psychological and social factors... (Underwood et al., 2017: 1327).

This *tension* may connect loosely to an element of control, however, when convergence is not seen, Mathison (1988) calls on the researcher to discuss why not, for full transparency. She states that when convergence is not found, the researchers need to *make sense of what we find* (Mathison, 1988: 17).

Exploring further the links between vulnerability and control, Baars (2012) enlightens us with his writings on aging. Focusing on the modern obsession with chronometric time, or as he sees it, the often negative value connected to an advancing numerical age, its number value, he writes:

Aging can be seen as a process of living in time, between the vulnerability and creativity of life on one side and the desire for control on the other. (Baars, 2012: 286).

At one level he sees ageing's vulnerability balanced with creative opportunity in old age, and then balanced with control. Here he explores control, but feels, compared to modern society's technological advancement, the personal nature of control humans have, has hardly developed, or advanced at all. This plays into a further interesting vulnerability and resilience tension. Therefore the control narrative from the phenomenological enquiry, which recognised vulnerability, mirrors the meta-aggregated finding of the systematic review (this vulnerability connection is developed further in the section below).

Thus, applying methodological triangulation to the three qualitative studies, as within the psychological domain of confidence's fear factor, control has significant presence and relevance as a result of the phenomenological enquiry, connecting well to the concept analysis, but with weaker links to the systematic review. The conclusion overall, therefore, is that there is a good level of convergence across confidence's domain of control.

The impact of methodological triangulation on the final concept analysis of confidence

The final part of the method triangulation must consider any change to the concept analysis of confidence in response to the findings of the phenomenological enquiry.

The Model case of the concept of confidence was that of Mrs. P. (Table 8). This would still have significant relevance as an example of what confidence is, for

assumptions to be tested against. Social connections, fear and independence are openly seen in the description. Where the phenomenological enquiry adds further weight to the model case, is through how the dimension of control is seen. For example, the dimension of control connects to frailty's vulnerability and resilience continuum, as well as recognising the intrinsic and extrinsic role control plays on the individual's confidence and the interdependencies with the other dimensions. Further reflection on this dimension of the phenomena of confidence leads to a rewriting of Mrs. P.'s model case (additions underlined):

Mrs. P. is 87 years old and lives with multiple morbidities. Six weeks ago Mrs. P. had a fall. She was frightened of having a further fall and this quickly affected her psychological well-being, she became quite anxious, not wanting to go out the house. This increased her vulnerability. Mrs. P. was promptly assessed at home by community healthcare staff who provided assistive devices and gave instruction and coaching on how they can be used to prevent further falls. As trust built in knowledge and use, so her resilience grew, strengthening her mental well-being and physical health. Mrs. P was supported to attend strength and balance exercise classes in her local community centre. This gave back control enabling her to regain the independence she was worried about losing and reconnecting her to important social networks again; she particularly enjoys her Tai Chi classes with her friends. This regained level of control and independence boosted her confidence, which in turn benefits her physical and psychological well-being.

The phenomenological enquiry's narrative descriptions of the four dimensions add further depth and richness of the reading of Mrs. P's mode. For example, these enhance understanding around how fear powerfully erodes confidence, thereby adding greater depth to the impact on her psychological well-being. Clearly, therefore, the phenomenological enquiry adds to the insight gained through method triangulation, bringing about a redefining of the conceptualisation of confidence.

Confidence: a new direction

Until now the four core findings that have emerged have been called dimensions. Dimensions are defined as *a part or feature or way of considering something* (Cambridge University Press, 2019) and have significantly enlightened meaning and understanding of the central elements of confidence, those essential themes. However, these *features* have been found to be deeper, richer, more dynamic and fluid than the separate columns presented in the initial concept analysis (Figure 8). By using mind mapping exercises, it was possible to start to explore what the richness of the phenomenological findings added to the concept. A grander, richer, much more informed concept emerges from the lived experiences. Figure 19 illustrates how key words from the narratives were connected to the essential themes. The biopsychosocial dimensions of the concept analysis appeared too restrictive and did not represent the latest findings, particularly those that were most closely connected to older people's meaning and understanding of confidence. They become more poignant when described as paradigms of confidence. Paradigms are defined as *very clear and typical examples of something, used as a model*

(Cambridge University Press, 2019). As such, there is a more concrete assertion of these four domains when constructed and presented as paradigms of confidence.

Four new paradigms now formed the four fundamental aspects of confidence's meaning and understanding that respect the narrative descriptions drawn from the in-depth conversations with older people. These new paradigms drew powerfully on the essence of confidence, aiming to evoke a stronger personal connection to the phenomena that will aid understanding and translation from theory to practice. Accepting paradigms are a collective of assumptions, beliefs and ideas (Guba and Lincoln, 1994), the titles of the previous four domains were strengthened and redefined.

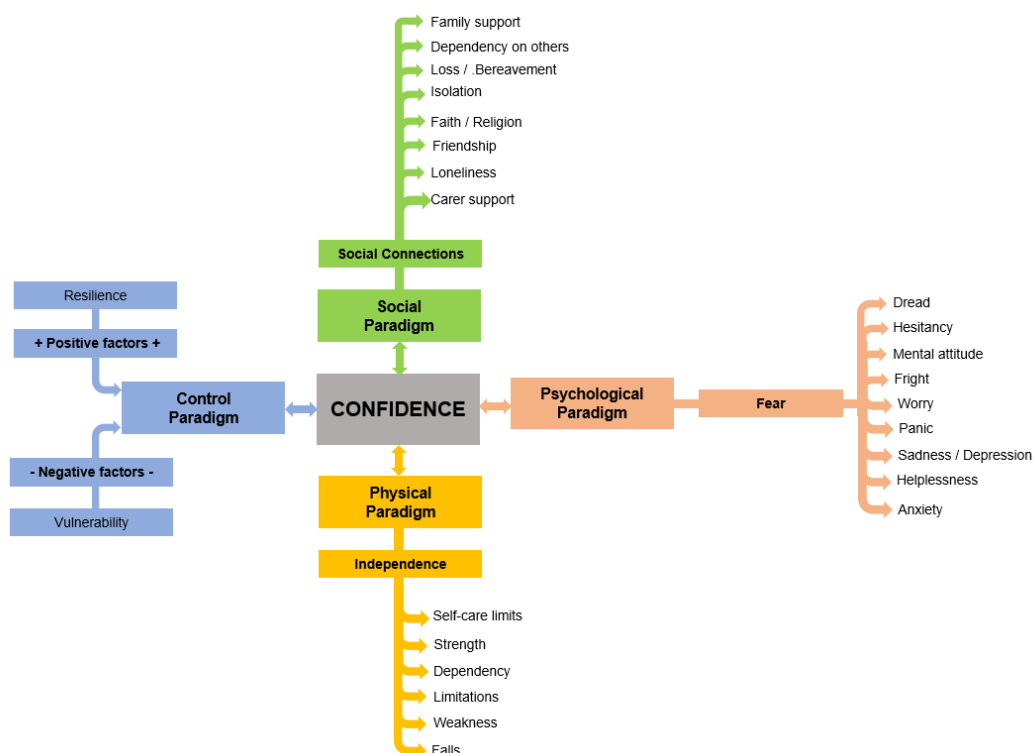


Figure 19: Mind map illustrating the emergence of paradigms in connection to the dimension of confidence and key words from their narratives.

They can now be presented as the four paradigms of confidence:

- The interpersonal impact on confidence through social connections with others: a social paradigm.
- The relationship of fear to confidence exposes a powerful and emotive effect: a psychological paradigm.
- Physical independence is a stimulus to confidence: a physical paradigm.
- The control of confidence is fundamental but not always achievable.
Control exists at the crux of vulnerability and resilience: a control paradigm.

The existing narratives reflected the richness of the lived experience of the older people from which they were derived. They complemented the attributes extracted through the primary concept analysis and, importantly, reinforced and strengthened the paradigm of control as the central element of confidence. Control appeared to have a greater existential ever-presence, i.e. the extrinsic control, influencing the other paradigms and the intrinsic control the older person personally felt they had. Furthermore, it also influenced the resilience and the vulnerability continuum. These intrinsic and extrinsic factors emerged when sketching out ideas during the process of starting to look for method triangulation connections (Figure 18), linking vulnerability to the frailty continuum. This was transferred to the new control paradigm, seen on the right in Figure 19 above. This represented a moment of discovery in the study's final analysis, where the researcher's interpretation of the frailty continuum, between resilience (assets) and vulnerability (deficits), was recognised and drawn into the final product.

Consequently, this led to rethinking the visual representation of the concept, from that in the published manuscript (Underwood et al., 2020). The visualisation was key to creating a channel of communication to practitioners and others about what the concept is, how it may be used when engaging with older people living with frailty and where confidence has been identified as an issue to address. A revised illustration (see Figure 20) of the concept presents this reorientation, capturing a more complex and dynamic concept of confidence as seen through the lens of older peoples living with frailty. Figure 20 now illustrates the four paradigms, three of which have been reworded to the directly reflect the essential theme titles for the phenomenological enquiry, and reoriented to the horizontal. They are presented by arrows to reflect their dynamic bearing on confidence, with the fundamental confidence-eroding and enhancing factors at either end, reinforced in words. The visualisations of the + and – symbols, from the concept analysis, point to how control's intrinsic presence within each paradigm exists, much more strongly than initially thought.

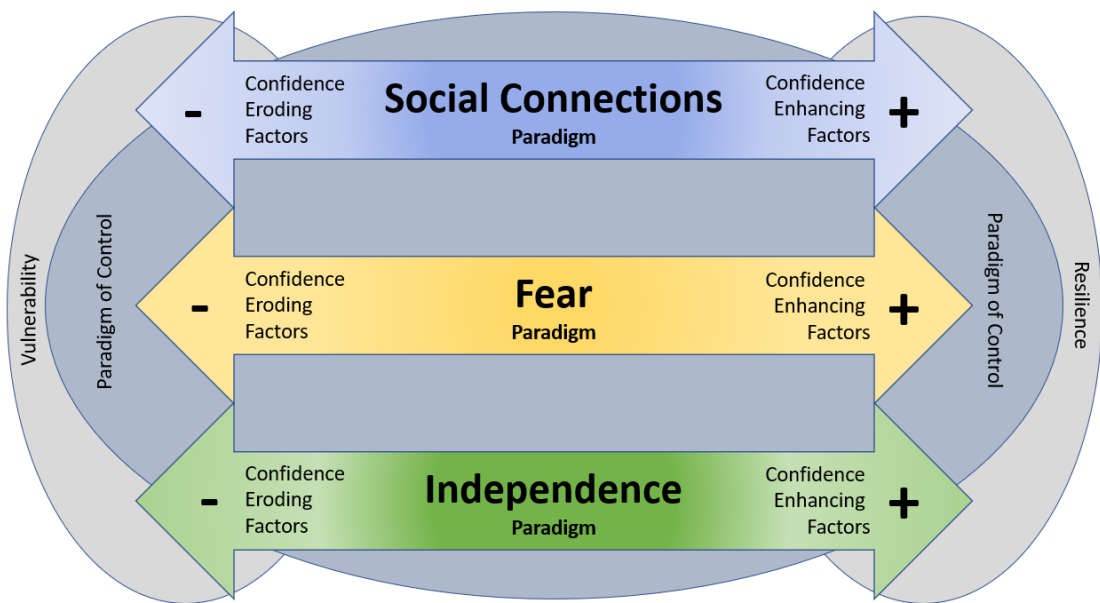


Figure 20: Illustration of the revised and final concept of confidence, illustrating the four paradigms of confidence that bring meaning and understanding.

The paradigm of control that surrounding the other paradigms connects to the extrinsic factors, which influenced personal control as witnessed in the phenomenological enquiry. Such as, the effect that being dependent on family members for help in the social context has on confidence, the influence of attitudes of healthcare staff on worry and fear, or in a *positive* and *enhancing* way, how being give a walking stick to aid your balance can boost confidence, with a subsequent regain in independence. Finally, in the background is the connection to frailty's relationship with confidence, as reflected by the continuum of resilience and vulnerability (This is explored further in the discussion chapter).

A concept description has also been developed and enhanced to aid communication and understanding of the concept:

The concept of confidence, through the lens of older people living with frailty, is controlled by a multitude of internal and external factors that can

either erode or enhance their confidence. Confidence sits within a continuum of frailty, between resilience and vulnerability, and is directly influenced by the individual's perceptions and lived experiences of social connections, of fear-factor and of their independence. This dynamic and interdependent concept is receptive to change through targeted interventions to strengthen resilience across these four paradigms.

This new visualisation and conceptual description needs to be meaningful to practitioners. Thus the visualisation of the primary concept analysis (Underwood et al., 2020) was revisited. Linking the new knowledge, derived through the method triangulation, back to the model case of Mrs. P, the new conceptualisation of confidence was adjusted to represent her lived experience, noting its more dynamic, interdependent and control-prominent features.

Figure 21 illustrates an adjusted conceptualisation of Mrs. P.'s confidence, at the point of assessment in the intermediate care setting following her fall, when she felt afraid and isolated at home. From the phenomenological findings it is clear that confidence is dynamic but it can be isolated and understood at a particular point in time. The social connections continuum reflects confidence shifted to the left of a centrally balanced position (referencing the balancing scale of illustrated by Rockwood (Figure 3). This position recognises her more vulnerable status due to isolation. The bar remains long, as intrinsically, she remains socially connected in some way to others, but still isolated in her home (telephone contact with family). The fear bar becomes concentrated, tightened by an all-encompassing worry of falling again and the fear continuum,

consequently, is shifted to the left also. The longer independence continuum bar represents her previous strength of physical and mental well-being (this would be pushing into the resilience bubble to the right). But again her confidence sits to the left of centre again, diminished from her previous normal balance.

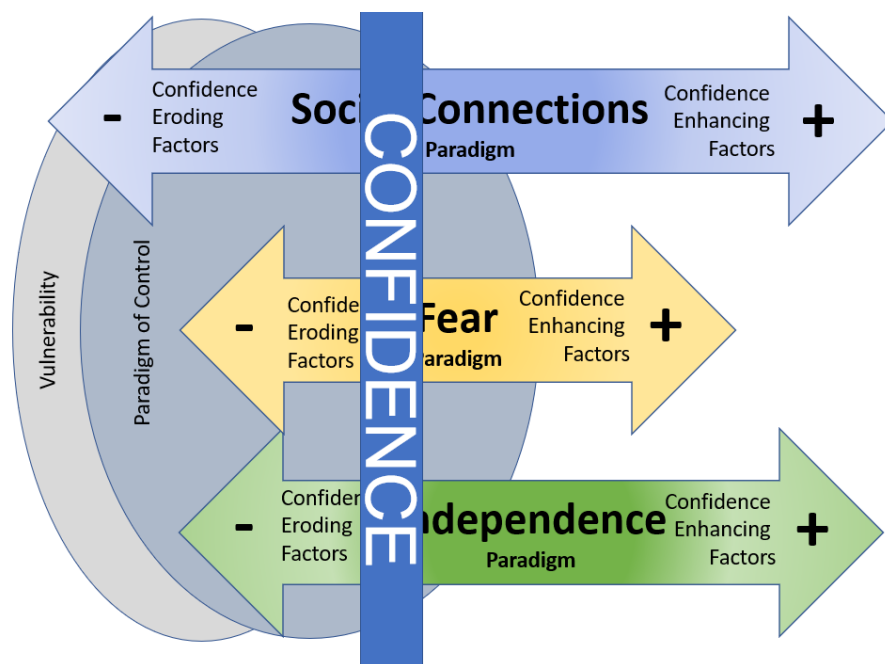


Figure 21: The new illustration of the concept of confidence adjusted to illustrate the primary concept analysis's model case of Mrs. P.

The paradigm of control has shrunk and sits in the negative area that reflects the vulnerable end of the continuum, illustrating at this time how extrinsic control factors are limited, flagging her current levels of vulnerability and risk to frailty progression. Attendance and assessment of needs by the community intermediate care team will enable Mrs. P. to see opportunities present and expand this extrinsic element of the paradigm of control. In time, Mrs.P.'s

confidence moves back to a more balanced position resulting in the vulnerability to her frailty diminish, along with some strengthening of her resilience.

Hypothetical examples such as Mrs P importantly present the new, more complex concept in a way that is helpful for others to start to understand and adapt new meaning and understanding to their own experiences. This translational aspect of the concept to practice is the ultimate test and is reflected on further in the next chapter.

Summary

Method triangulation has been used in the final stage of the wider study, drawing the findings of the three qualitative studies together to form the final product; a conceptual framework for confidence from the perspective of older people living with frailty to consider practice implications.

CHAPTER 8:

THE PARADIGMS OF CONFIDENCE:

CONTRIBUTION TO KNOWLEDGE

Introduction

It is from the perspective of the older person living with frailty that this unique enquiry has been built. Commonly, confidence is expressed in its noun form – as a ‘thing’, like former First Lady to the US President, Eleanor Roosevelt expressed in her book:

You gain strength, courage, confidence by every experience in which you really stop and look fear in the face. You are able to say to yourself, ‘I lived through this horror. I can take the next thing that comes along’.
(Roosevelt, 2016)

She died two years after its publication, in 1962, at the age of 78. From a more contemporary perspective from older people, findings from the three interconnected qualitative studies have been presented in the preceding chapter and it has been argued that this incremental knowledge building approach was appropriate to answer a specific clinical practice based question. A final concept of confidence has been created through method triangulation; a process that indicated overall strong convergence. This discussion chapter sets out to explore originality in this new knowledge, through the concept’s four paradigms of confidence. It will discuss the findings in relation to contemporary

models of frailty practice and healthcare's strategic direction in England, aimed to improve the physical health and mental well-being of older people living with frailty. The chapter will conclude by summarising implications for practice and future research, along with a critical reflection on the trustworthiness of the final concept.

The primary aim of this doctoral study was:

To explore and develop a concept of 'confidence' in the context of older people living with frailty and consider implications for practice.

The development of a concept of confidence

This study's sequenced approach to knowledge discovery has been faithful to the Knowledge to Action Framework (Graham et al., 2006), specifically its central knowledge creation component. Knowledge searching, finding, filtering and synthesising enabled the initial meaningful interpretation of understanding to be brought to an emerging concept of confidence from the perspective of older people living with frailty. The Knowledge to Action framework is one of the most cited conceptual structures for knowledge translation. Field et al. (2014), in their systematic review of the framework, identified significant variation in application across studies, from single citations, to being fully embedded within implementation studies. Accepting this critique, a commitment to faithfully respect the knowledge creation processes to produce a final product for

application into practice has been fulfilled. It was not within the scope of this research to proceed with action / implementation, the outer cycle of activity the Knowledge to Action framework extols (Graham et al., 2006); that forms the next stage of this programme of enquiry . However, new knowledge development, that has a practical application to clinical practice to impact on outcomes of older people living with frailty, has been achieved.

Responding to the systematic review's limited findings, which could not support a more concrete revelation to be formulated, the literature was revisited.

Answering its recommendations, a wider body of confidence relevant literature was analysed in order to develop a primary concept of confidence. This concept analysis became a new contribution to academic knowledge. A further new contribution is made in the third stage of the study, the phenomenological enquiry. This brought a welcome collection of additional voiced experiences of older people living with frailty to the literature, which have informed and shaped a final analysis of the concept facilitated by methodological triangulation, to create this final product.

The ultimate aim of the study was reinforced at each phase of this research by using different research approaches in order to tailor new knowledge to practical and pragmatic end points (Graham et al., 2006). The rationale behind this programme of work has been articulated throughout and the outcome has been to produce a conceptual framework with practical, problem solving capacity for real world application.

Original knowledge discovery

The final concept is constructed of four interdependent paradigms – social connections, fear's psychological connection, physical independence and control (Figure 20). Each separate study developed findings congruent with these physical, social and psychological level paradigms. These are undeniably consistent and prominent threads that run throughout this study and translate to the familiar healthcare practice related biopsychosocial, medical model of George L. Engel (Engel, 1977, Borrell-Carrió et al., 2004, World Health Organization, 2013). Concentrating on these three paradigms, consideration regarding researcher bias needs first to be assessed.

Suggestion could be made that findings were engineered to aid acceptance and adoption by practitioners, as familiarity is assignable to this well-established model in practice. In response to such suggestions the researcher argues that rigorous demonstration, throughout this thesis, has drawn on the experiences of confidence, through the words spoken by older people, over and over again. An authentic honesty and openness to this human insight has been realised through the commitment to delivering this study within a structured human science approach. This is witnessed in the findings chapter and supporting appendices; the demonstration of integrity, responding to and focused always on the research question. Study conduction and final analyses reflect this too. It is important to acknowledge that, at the very highest communicable level, findings can be articulated to practitioners of practice and of research using the domains of the biopsychosocial framework (physical, psychological and social). However, the strength of the concept is underpinned by the *defining*

characteristics that sit within this framework: social connections, fear and independence. Its understanding is enhanced when presented alongside the rich and descriptive narratives of these paradigms (Appendix 8). It is argued that these detailed narratives, provide meaningful insight and delivery of the future impact for older people. In the detail, in their connected and interconnected attributes, the richest answers to the questions of confidence are held. These provide a new comprehension of confidence, opening promising opportunities to enable important interventional investigations to commence.

Taking a step or two back, to the start of this study, we remind ourselves of the recommendations from the original knowledge discovery stage, in which two significant questions were presented:

- *What is this concept of confidence? ([recommending to researchers] construct the concept of confidence for this frail population.) and;*
- *How does the concept of confidence connect to and influence frailty experienced by older people with respect to their physical health and mental well-being?* (Underwood et al., 2017: 1329-1330)

The concept analysis and phenomenological enquiry attempted to address these questions. The primary concept analysis responded to the first question, *what is this concept of confidence?* Both subsequent studies respond to the second question where the emergence of the fourth essential theme, the paradigm of control, emerged and grew in importance. This fourth paradigm influences confidence in positive and negative directions. Through this research it is now possible to understand more fully, through time spent interpreting the phenomenological enquiry data and with method triangulation, how confidence is strongly linked to the balance between an individual's resilience and

vulnerability, and as such is directly connected to the older person's physical health and mental well-being, and indeed their frailty.

This discussion chapter continues now to explore the unique contribution of this body of knowledge. It individually scrutinises real-world context to the four paradigms, starting with the social paradigm.

The paradigm of social connections

The interpersonal impact on confidence through social connections with others: a social paradigm.

Rahman (2019) emphasises the importance of social health to older people living with frailty. With an asset-based focus on frailty, he illustrates aspects of social health in a context of socioeconomics, mastery of control over life circumstances, social support from family and friends, social engagement in group activities, social capital and social cohesion (Rahman, 2019: 118). The conceptual opposite of social health that appears in the literature is social vulnerability (Andrew and Keefe, 2014, Andrew, 2010) This moves away from any assets based view, as social vulnerability in research is often connected to mortality studies of older people to unearth its meaning. Social vulnerability is defined by Andrew and Keefe as:

... the degree to which a person's overall social situation leaves them susceptible to health problems, where "health problems" are broadly construed to include physical, mental, psychological and functional problems. (Andrew and Keefe, 2014: 1)

Their cohort study focused on social vulnerability linked to survival over ten years of older adults from the National Population Health Survey of Canada. They recognised seven unique factors that explain their *robust, yet limited* social vulnerability model: *living situation, self-esteem, sense of control, relations with others, social support, engagement and contextual socio-economic status*. (Andrew and Keefe, 2014: 7-8)

Vulnerability was the aggregated data finding of the systematic review. Many features of the Andrew and Keefe (2014) definition of social vulnerability are mirrored in the review's findings on confidence. Disappointingly, this was not a connection made at that time. Stronger connections could have been made referencing the impact of the stroke survivors community group (Beesley et al., 2011) or the new social connections the orthopaedic home rehabilitation programme brought older participants (Tung et al., 2013).

The term social frailty is another concept introduced by Rahman (2019), citing Makizako et al. (2015), who assess this by a series of questions exploring:

... if people lived alone, if they go out less frequently than the previous year, if they are visiting friends sometimes, or feel helpful to friends and family, and if they manage to talk to someone every day. (Makizako et al., 2015: 118)

This idea of social frailty has an important presence too in the authentication of this social paradigm of confidence. These multiple social concepts can be seen on a continuum. Social vulnerability at one end and at the opposite end is social resilience; described as the assets held by an individual, keeping them healthy through social connections (Rahman, 2019). Balancing these assets and deficiencies (the latter leading to increasing vulnerability) are associated with a

number of frailty models described earlier in Chapter 2, including that by Rockwood et al. (1994) in which frailty is seen as a balance between health and illness. This can be seen to influence a parallel continuum, that between social health and social frailty (Figure 22). The latter is a measurable feature of the model underpinning the Tilburg Frailty Indicator (Gobbens et al., 2017), consisting of three components: living alone, lack of social relations and lack of social support.

These two social continuums (health and frailty, and resilience and vulnerability) contain numerous intrinsic and extrinsic features that affect older people living with frailty.

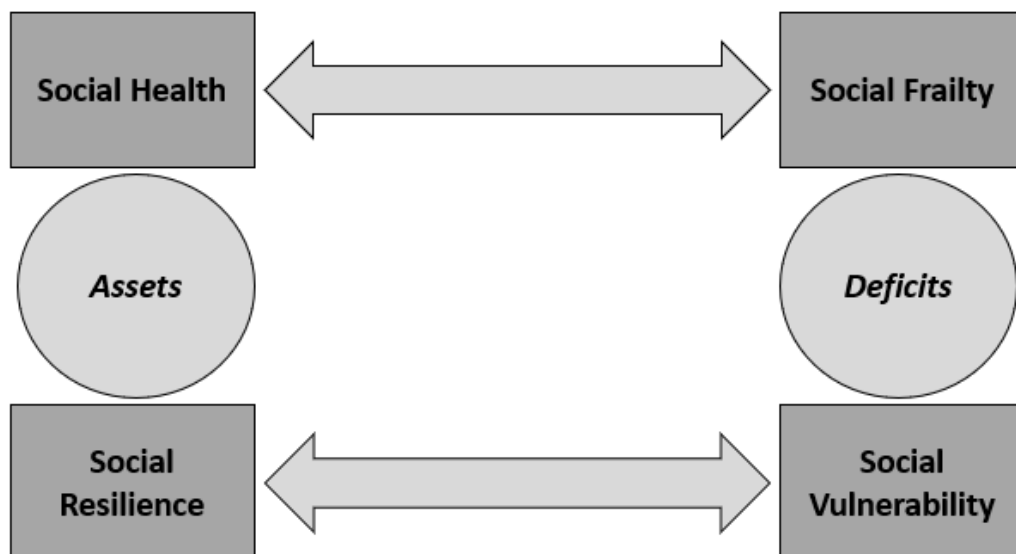


Figure 22: Illustration of the social constructs present in the literature presented on parallel continuums.

These strongly resonate with the social paradigm presented in the ultimate findings of this thesis, particularly in the last section of the social paradigm narrative:

... In strength the connection with family, friendship and companionship gives confidence, hope and optimism. If this bond to others is broken, either permanently or temporarily; through loss of a spouse or abandonment of friends, or to the fleeting trust held in the carers supporting them, this broken connection leaves a person holding on to a frail confidence; a vulnerable confidence. (Table 19).

The contextual references: *loss of a spouse, abandonment, and fleeting trust of carers* (Table 19) are directly attributable to the lived experiences of confidence in older people living with frailty. Jonasson and Berterö (2012) studied the ethical and interpersonal component of approaching the caring encounter between the nurse and older patient. They identified the influence the healthcare professional has on the older patient's feelings of security and confidence in caring situations. This strongly relates to the lived experience of participants from the phenomenological enquiry that informed the narrative: *fleeting trust of carers*. It reinforces the importance of educating staff on the impact they have with each and every patient encounter. All three contextual references from this extract describing the social paradigm focus on the negative, which is in contrast to the Nicholson et al. (2013) study exploring the experience of living at home with frailty. They emphasised, from interviews with older participants, that loss of social connections for older people is balanced with effort to sustain other relationships and create new ones. They relate this to a lived frail vulnerability. Losing, creating relationships, and sustaining them is a continuum of social connectedness. The same continuum is echoed too, in the

negative, by Andrew and Keefe (2014) in their social ecology study exposing social vulnerability.

Thus these relationships, family, friends or professionals are important social connections, referenced and reinforced throughout the connected literature. This meaningful presence of others to engage with older people with frailty, gives a direct connection to these social continuums and importantly to the concept of confidence. As discussed in Chapter 7, these continuums, particularly the frailty continuum with its tensions between resilience (assets) and vulnerability (deficits) triggered a moment of discovery in this study's final conceptualisation of confidence.

The paradigm of fear

The relationship of fear to confidence exposes a powerful and emotive effect: a psychological paradigm.

The psychological connection to confidence in older people with frailty has had less attention in the literature than the social connection. Indeed fear, the central psychological finding of this thesis, is nearly invisible outside the body of literature relating to the fear of falling (Boyd and Stevens, 2009, Painter et al., 2012, Ribeiro and Santos, 2015, Tinetti et al., 1990). Rahman (2019) focuses on cognitive frailty, using the tipping point most often seen in practice to illustrate this; when delirium presents and strips away any asset and resilience the individual has built. A powerful example of this is presented through the reported conversation of Participant 11 from the phenomenological enquiry.

Participant 11 describes her lived experience of delirium, stripping away her confidence, describing it as a mental frailty (Referenced in Chapter 6 and detailed further in Appendix 3).

Cognitive frailty, however, is characterised by the simultaneous presence of both physical frailty and cognitive impairment (Kelaiditi et al., 2013). Andrew et al. (2012) are cautious in reporting strong causality as they evidenced from a population-based sample of community dwelling older Canadians. They state that poor psychological well-being and frailty were correlated, suggesting *a bi-directional relationship, in which decline in health and function and in psychological well-being occurs in tandem and in response to one another ...* (Andrew et al., 2012:1351).

Since then, much research attention has focused on measuring prevalence and reporting interventional studies in this area (Arai et al., 2018a). This interest in frailty and cognitive impairment is important. However, in seeking originality in knowledge discovery within this thesis, it was important to understand confidence from the perspective of this psychological paradigm's focus. A deeper exploration of the frailty associated evidence is still necessary.

The psychological is not evident in the early dynamic frailty model of Rockwood et al. (1994). Even the latest Tilburg Frailty Indicator (Gobbens et al., 2017) has limited detail of meaning or connected relationship to frailty. Its *psychologic* frailty definition is linked to a decline in cognition, mood and coping. The latter two elements were echoed by some participants in the phenomenological enquiry, but not all, and seem quite distant in relation to the fear factor that emerge. Rahman (2019) cites the Franklin et al. (2012) review of neural mechanisms on stress, resilience and vulnerability. These indicate the important

role coping strategies have on resilience in supporting individuals to *deal with challenges, facing fears, problem solving and seeking social support* (Rahman, 2019: 21).

In a dated paper, Gubrium (1973) positions fear in the context of the then differing schools of thought on the subject (such as William James, Sigmund Freud, Hobart Mowrer and Donald Hebb). Gubrium studied expressions of fear in over two hundred older people. He defined fear as a state of mind, characterised by desperation and anxiety that grew from a personal level of incompetence in coping with events of everyday life (Gubrium, 1973: 111).

Connecting fear with anxiety (mood on one level) and coping, links with the Tilburg Frailty Indicator (Gobbens et al., 2017). Although Gubrium's focus was broad, concentrating more on social factors, such as their social environment and financial security, he did report a section on fear of losing independence. This included the fear of losing one's health, work and *the death of a spouse or some other person in whom one had confidence* and, thus becoming a burden (Gubrium, 1973: 117).

These connections to fear resonate strongly in the findings of this thesis. They also demonstrate and reinforce fear's interwoven connection with the physical and social paradigms.

Looking further at the findings of this thesis, in relation to other studies, the *mental frailty* phrase of Participant 11 and its impact on confidence resonates. In a review paper describing the relationship between mental frailty and older people, McDougall and Balyer (1998) highlight a correlation between depression, anxiety, self-efficacy erosion (which could be considered as

confidence loss here), and mental frailty in older people. As reported in the concept analysis paper (Underwood et al., 2020), McDougall and Balyer (1998) fall into the self-efficacy/confidence trap, stating:

The concept of self-efficacy may be defined as our confidence in our ability to perform effectively in a given situation. (McDougall and Balyer, 1998: 2)

However, looking beyond this, they go on to state:

Repercussions of this lack of confidence in memory ability may include a generalized negative self-concept, the perception that others have a better memory than they, and a fear of impending senility or dementia. (McDougall and Balyer, 1998: 2)

Here a connection between lack of confidence (however interpreted) and fear is intimated, strengthening the connection between fearfulness and confidence that this thesis asserts. McDougall and Balyer (1998) surmise possible consequences of a downward spiral of cognition and physical frailty that include avoiding social interactions which involve recalling names. This complex and interwoven world of frailty and its components are reflected strongly in this paradigm.

Recognised in the opening sentences of this section, the substantial body of literature on the fear of falling cannot be ignored. There were significant numbers of participants in the phenomenological enquiry citing this association. However, the essential theme that emerged was fear, not fear of falling. This recognises a multidimensional element to fear, not a unidimensional connection to falls alone, however complex its deconstruction (Painter et al., 2012, Ribeiro and Santos, 2015). Rahman (2019) provides a useful summary on the subject

and also recognises that, in most studies, the fear of falling is related to self-efficacy concepts. Recognising falls and the fear of falling can significantly reduce quality of life and independence. He cites Bodenheimer et al. (2002) and states:

Based on improved self-efficacy patients can regain control of their own lives, gaining new confidence in their ability to perform a task, hence increasing self-management. (Rahman, 2019: 63).

Connections here with falls and to self-efficacy flow into the other two paradigms in this discussion chapter – independence and control. There is however a cyclical connection between fear (broad), fear of falling (specific), self-efficacy (its connection to fear of falling) and confidence (often misinterpreted in the literature, but an evidenced antecedent and consequence of fear) all sit within this psychological paradigm.

The debate over any legitimate nexus between self-efficacy and confidence has been omnipresent throughout the duration of this study too. From early protocol development, preparing for the systematic review (Underwood et al., 2015) through to the discussion section in the concept of confidence publication (Underwood et al., 2020) to now. It must be questioned whether this researcher's stance, to separate the two has supported or constrained this study's findings. Self-efficacy has never been far away, hovering in the background. The distance the researcher has laid between it and the central focus of the study has been guided from the very start by Bandura's words:

...[his] construct of self-efficacy differs from the colloquial term 'confidence' (Bandura, 1997: 382).

This view, that they are not the same, drove the exploration of new knowledge, as his words are interpreted to mean: 'If you want to know what confidence is? Look elsewhere, not in this construct of self-efficacy'. Logically however, can it be expected that all researchers who are interchangeably using the two words understand Bandura's stance? Evidently not. Therefore, in the pursuit of original knowledge discovery, this researcher has consistently argued to maintain this essential divide. This divided nexus has been openly disclosed, debated and should be finally concluded here to allow a final appraisal. There is little published beyond Bandura's original statement, here in full:

It should be noted that the construct of self-efficacy differs from the colloquial term "confidence." Confidence is a nondescript term that refers to strength of belief but does not necessarily specify what the certainty is about. I can be supremely confident that I will fail at an endeavor. Perceived self-efficacy refers to belief in one's agentive capabilities, that one can produce given levels of attainment. A self-efficacy assessment, therefore, includes both an affirmation of a capability level and the strength of that belief. Confidence is a catchword rather than a construct embedded in a theoretical system. Advances in a field are best achieved by constructs that fully reflect the phenomena of interest and are rooted in a theory that specifies their determinants, mediating processes, and multiple effects. Theory-based constructs pay dividends in understanding and operational guidance. The terms used to characterize personal agency, therefore, represent more than merely lexical preferences. (Bandura, 1997: 382)

This legitimised position of Bandura puts separation between self-efficacy and confidence, which has never been academically challenged or argued. The positioning comes down to a theoretical construct against a *lexical preference*. It is argued in this thesis, and published papers, that this divide exists, and separation was essential to allow an independent exploration of confidence to be made. Through this original research of discovery, a new conception of confidence has been built. Accepting that this is a novel new (immature)

concept (Morse et al., 1996), it is one which will need testing out post-doctorally in the real world. This new concept provides a framework for theory to be built, in the context of older people living with frailty at least. Time will tell, as it becomes adopted or if any challenge to self-efficacy itself is made through its presence. This physiological paradigm of fear has significant connection to contextual literature and practice to support adoption. Again, the cross cutting paradigm of control is present.

The paradigm of independence

Physical independence is a stimulus to confidence: a physical paradigm.

The physicality of frailty is dominant in the literature. The historical overview of frailty in Chapter 2 reinforces this. However, confidence's physicality, in the findings of this thesis are fundamentally connected to independence. The narrative of the paradigm opens with the sentence: *The determination to be independent is a physical driver for confidence* (Table 21).

This goes on to describe an individual's motivation to tackle a suboptimal confidence. A concept analysis of self-determination and older people emphasises independence and control factors (Ekelund et al., 2014) They identify attributes that repeatedly appear in the literature reviewed as being: *the ability to make a decision, to have knowledge, act, and/or make decisions based on one's own free choice, to have control in the process, and legal/ethical rights* (Ekelund et al., 2014: 3).

Choice and control play into the final paradigm to be discussed in this chapter, focusing on the other attributes of self-determination: ability and knowledge to make decisions. Ability relates to cognitive ability and plays on early discussions of cognitive frailty. Knowledge, however, relates to a number of conversations within the phenomenological enquiry. Knowledge was seen to hold back participants' independence through not knowing what family members' thoughts about discharge were; not knowing or learning which staff members who were on duty today; not knowing enough about their physical strength and their ability to self-care; not knowing about the support services in the community; and not knowing about progress being made to get out of hospital. These are some examples from the phenomenological enquiry and all relate to lack of knowledge and its connection to low confidence. Skymne et al. (2012) explore how older people living with frailty experience and adapt to assistive devices, such as a walking frame, to support their independence in their activities of daily living and self-care. Knowledge and experience were key components to participants' growing confidence, resulting directly in more physical independence. This would link to asset building attributes promoted by Rahman (2019). A juxtaposed deficit, physical weakness, is often referred to in those lacking confidence. This weakness connects to the Fried et al. (2001) frailty phenotype, related to a self-reported exhaustion. The syndrome of sarcopenia is associated with muscle weakness and connected to frailty (Cruz-Jentoft et al., 2019). In this literature, reference is often to physical function rather than physical independence. Sarcopenia is characterised by progressive loss of muscle quality and quantity, on walking gait particularly, which limits physical function, but arguably physical independence too.

Often, the context of confidence and independence is associated with education and training. Interventional studies in sarcopenia management has demonstrated an improvement in muscle capacity through physical exercise and activity in older people living with frailty and who suffer long-term health restrictions such as Chronic Obstructive Pulmonary Disease or Heart Failure (Arai et al., 2018b). Knowledge and education are components in the concept analysis model case:

She was promptly assessed at home by community healthcare staff who provided assistive devices and gave instruction and coaching on how they can be used to prevent further falls. As trust built in knowledge and use, so her mental well-being and physical health grew. (Underwood et al., 2020: 746)

However, this was not strongly present in the phenomenological enquiry findings of lived experience. Across the phenomenological enquiry, it was noted that confidence impacted on how *quickly the person's ability to physically look after themselves, to self-care, can be affected* (Table 21).

Motivation for self-care and independence are interconnected in the study's findings. Soderhamn et al. (2013) investigated the meaning of the actualisation of self-care. Their analysis revealed four themes:

Desire to carry on [physical activity], Be of use to others, Self-realization [control over future choices], and Confidence to manage in the future. (Soderhamn et al., 2013: 3-6)

This is insightful in the context of the concept of confidence with regard to its mirroring multi-dimensional construct with relationships to physical, psychological and social dimensions. However, their findings were extracted

from older people (aged between 67 and 89). Frailty was not identifiable, although many describe living with chronic long-term conditions. It does provide an important confidence relevant adjunct by clearly articulating self-care from the lived experience of an aged population.

The confidence to manage future challenges was an important finding (Table 21). This resonates with the comments from healthcare professionals' experiences from the phenomenological enquiry. Many cited confidence connections to how patients spoke about their ability to 'manage' and how they saw themselves not managing as well in the future. Another paper by Soderhamn (2013) states:

Successful selfcare involves having contacts with the health care system [this is in the context of recognising human beings undergo self-care transitions across life's course, often in connection with healthcare professionals p.606], being conscious of a sound lifestyle, being physically and mentally active, being engaged, having social contacts with family and others, as well as being satisfied, positive, and being able to look forward. (Soderhamn, 2013: 605)

This further reinforces, for this paradigm of physical independence, its multiple connections to the other paradigms the concept of confidence exposes.

The paradigm of control

The control of confidence is fundamental but not always achievable. Control exists at the crux of vulnerability and resilience: a control paradigm.

Control in the context of the concept of confidence has evolved to be a more complex paradigm, critically interacting and influencing the other paradigms of

the individuals' experiences. It is not surprising that control, as a broad concept, is one of the most widely explored topics in the fields of psychological and social sciences (Walker, 2001). There are a number of definitions for a wide range of control types (Table 24).

Table 24: Definitions of different types of control.

Cognitive control - the process or stage of mental activity that controls other mental activity.

Emotional control - the influence we exert on our emotions, thoughts and behaviour.

External control - the belief that one's experience and behaviour are determined by luck, circumstances, other people and external factors.

Internal control - the belief that a person is responsible for the consequences of their behaviour and is able to take action to deal with problems arising from it.

Locus of control - is a construct which attempts to explain the reason behind an individual's basic motivational orientations and their perception of how much control they have over their day to day activities and general life.

Motivational control - is one's ability to self-manage or regulate attitudes and feelings to directly affect receptiveness to an outcome.

Perceived control - the degree to which an individual believes an action is under their active management.

continued

Primary control - a conscious effort by an individual to gain a sense of control around their surroundings. It is their attempt to directly alter their environment with actions they initiate.

Secondary control – a behaviour pattern which does not directly control the environment but is intended to alter oneself to be more compatible with the environment by implementation of changes in values, priorities, or behaviours.

Self-control - a person's ability to control emotions and behaviour and to limit our impulses. Having this ability enables a person to control over his emotions.

Social control - the power of organisations, institutions and the laws of society to influence and regulate behaviour.

Voluntary control - the management of acts or behaviours by intentional action.

(N. and Pam, 2013)

It has been argued from the outset of this thesis that this level and range of theoretical language and complexity of terminology brings an intellectually inaccessible evidence base to healthcare professionals working in acute hospital and post-acute care settings. This consequently makes translation and application to practice challenging (Underwood et al., 2015). From the paradigm of control's narrative definition of confidence (Table 22), there are multiple cross-references to the types of control identified in Table 24 above:

Some older people living with frailty have a natural belief in the control they have over their confidence. These people often refer to their

experience of confidence over their life-course, a confidence that has been shaped, by themselves, but often by others. (Table 22)

This reflects *primary control* and *external control* elements; these are referenced as extrinsic control factors in the primary concept of confidence manuscript (Underwood et al., 2020). The next section of the paradigm of control narrative from the phenomenological enquiry states:

...as frailty becomes recognisable in their bodies and minds, the vulnerability of control over their confidence may falter and they become hesitant. This vulnerability is influenced by a reliance on other social, psychological and physical factors. (Table 22)

Here echoes of *internal control* and of *cognitive* and *emotional control* are evident (Table 20). These intrinsic control elements are visible in the next section of the narrative:

... Mental or psychological control over matters of confidence help some people, but mental fragility removes this control quickly and can rapidly take confidence away from their grasp. (Table 22)

Motivational control (Table 20) can be seen in this next section:

... Regarding physical factors and independence, strength building and activities like goal-planning and target setting to regain mobility and self-care capabilities help give control back. (Table 22)

The final section reinforces that reflected above:

...The constant tension between the person's internal control over their confidence and external control or controlling factors that affect their inner confidence. (Table 22)

Consideration needs to be given to how this concept of confidence's broad adoption and description of control is positioned within an academic worldview. This lack of specificity can be criticised. However, drawn from the seventeen confidence conversations of older people living with frailty, paradigms of control were always present. Control was accentuated across a range of internal and external circumstances, reflecting many types of control set out in Table 24. On another level, this may align much more closely to the definition of Locus of Control (Table 24) and an area of established research with older people (Lachman, 1986). Locus of control has this broad contextual reference too. Milte et al. (2015) recognises that:

... health locus of control refers to the extent an individual believes their health is controlled by themselves and external sources. (Milde et al., 2015: 314).

Milde et al. (2015) investigated the more contemporary influence of health locus of control on physical function, quality of life, depression and satisfaction with discharge arrangements of older adults living with frailty after a hospital admission. A multiprofessional coaching intervention was provided to the patient over the transition of care phase, to increase involvement in healthcare planning. They reported only a small improvement in personal control over health, quality of life and physical function at 12 months. The authors acknowledge numerous study limitations, however, they did highlight the important effect that an individual's psychological beliefs, including health locus of control had on health and well-being measures over time, especially when recovering from acute illness or injury. Milte et al. (2015) believe that the modification of control beliefs has the potential to promote resilience and impact on health outcomes in older adults during care transitions.

This all reinforces that a dynamic element of control sits across the continuums of the social paradigm explored earlier (Figure 23).

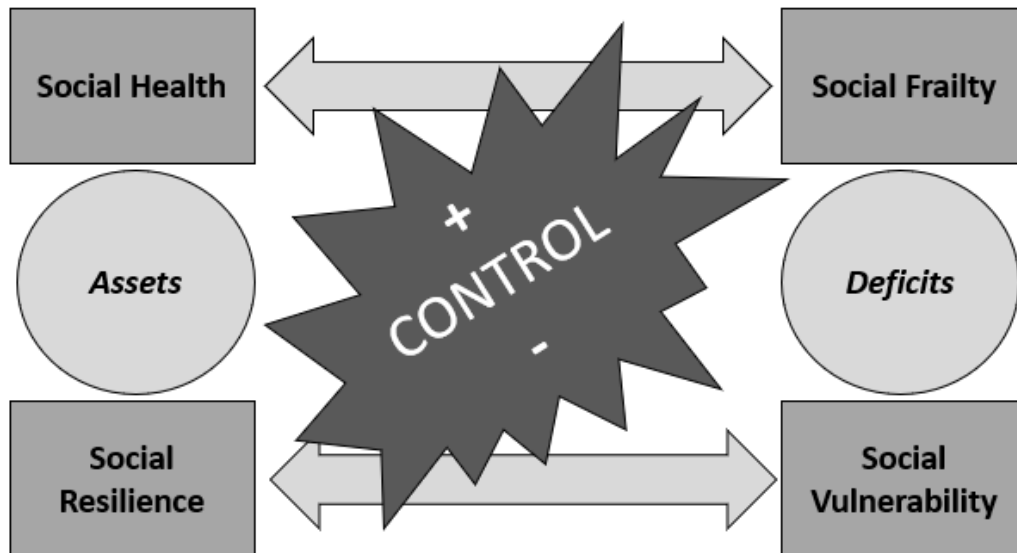


Figure 23: Illustration the dynamic element of control in context of parallel continuums of the social paradigm.

Walker (2001), frustrated by the range of control related concepts, such as perceived control, self-efficacy, locus of control and learned helplessness, provides an extensive critique of these from the fields of health psychology formulating a new unified concept of control. She carefully positions the other constructs and connects them to two additional constructs; social support and emotional state (anxiety, fear and depression). Her refreshing new unifying theory makes several important associations relevant to the concept of confidence developed in this thesis. Specifically, in understanding the multifaceted and dynamic presence of control. Walker (2001), critical of research studies and papers that lack terminology definitions, clearly states her

position. The verb control refers to: *actions taken by the person and / or others to attain a desired outcome*. The noun control refers to: *the attainment of a desired outcome through the actions of the person and / or others* (Walker, 2001: 178). This unifying theory of control is illustrated in Figure 24, the x and y axis recording the degree of perceived support and perceived control respectively.

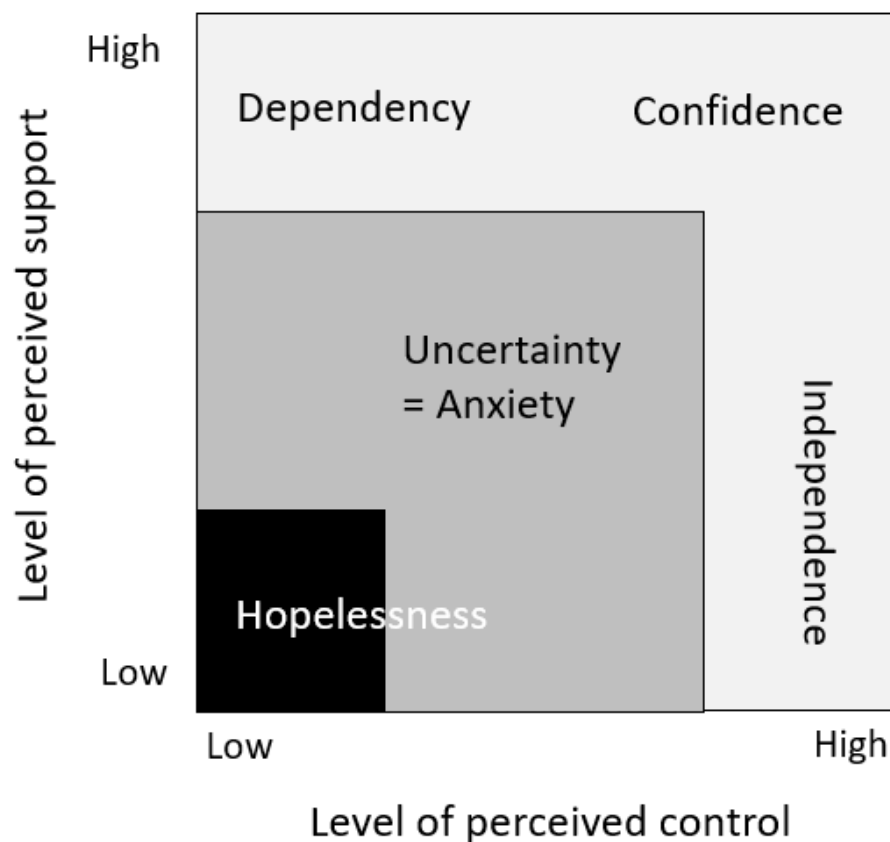


Figure 24: Interpretation of the Walker (2012) illustration of a unifying theory of control.

Layering her new theory with the established concepts of control she explores in her book, Walker (2001) introduces the dimension of uncertainty in control (illustrated in central darker grey square in Figure 24), the: *I don't know what is*

going on and; unpredictability, *I don't know what is happening*, both connected to anxiety. This is present in the breadth of middle ground in a person's perceived level of support and of control.

The dimension of uncontrollability, the *there is nothing I or they can do about it* (illustrated as the small black square in Figure 24) is when the lowest levels of perceived support and control exists within the person. Walker (2001) cites the original work of Seligman (1975) and the literature on hopelessness and depression and its negative impact on control (Walker, 2001: 179).

Dependency and independence are both present in the concept of confidence's physical paradigm and exists in Walker's unifying theory of control too. High perceived support and low perceived control result in dependency and the opposites, low support and high control, result in the feeling of independence.

At high levels of both, perceived support and control, comes confidence. This suggests an importantly strong interdependency between the social paradigm of confidence and the cross-cutting paradigm of control, which is greater than that between control and the physical or psychological paradigms. However, Walker's unifying theory is underpinned by several other theoretical propositions (Table 25). These relate to and appear within the other paradigms of confidence. They become important when considering the shift to prominence of the control paradigm in the final concept analysis (through method triangulation). The interwoven elements of helplessness and hopelessness are recognised, as are the prominence of uncertainty and anxiety, and of dependency and independence. Walker recognises spirituality's presence in perceived control (Table 25, fifth bullet point) that echo in lived experiences of

some conversation from the study. Other paradigm connections include that with fear, social support and social connections, vulnerability, the positive and negative and the internal and external dimensions of control (Table 25). These grow in further importance when considering adopting this unifying theory of control in future research applying the concept of confidence in practice.

Table 25: The theoretical propositions underpinning Walker's unifying theory of control.

- Control reflects the attainment of desired outcomes in a given situation.
- Control may be achieved through the actions of self or others.
- Perceived control normally reflects actual control, though illusions of control may occur under normal conditions by chance. It is also influenced by past history of control and lack of control.
- External (other) control relates directly to the achievement of desired outcomes through the actions of others and is equivalent to the instrumental social support.
- Chance locus of control may reflect uncertainty about the availability of internal or external (other) control or may reflect a third orthogonal (spiritual) dimension.
- Perceived uncertainty and perceived unpredictability are sufficient but not necessary conditions for perceived uncontrollability.
- Perceived control is associated with confidence and optimism.
- Perceived uncertainty and unpredictability are associated with anxiety.
- Perceived uncontrollability is associated with fear, anxiety and/or depression.
- Sudden total loss of control may result in helplessness, anxiety and depression, which is distinct from hopelessness depression.

continued

- Perceived personal control and perceived social support should be viewed as complimentary variables in relation to control.
- Personal control is preferable to social support, since it is more reliable and sustainable.
- Emotional and informational support should be interpreted as the types of support that enhance sense of personal control.
- Instrumental support is adaptive if it fulfils needs that cannot be met through self-care. It is maladaptive if it usurps personal control and leads to a relationship of dependence.
- Sense of control may be bolstered by spiritual beliefs (represented by belief in an external source of support). Whether this is real or illusory is a matter of personal belief.
- Perceived control and support are dependent on frame of reference. What observers view as dependence may be perceived by the actor as control.
- It is important to ensure that back-up control and support strategies are in place to protect vulnerable individuals against sudden loss of one or the other in the longer term.
- Positive and negative emotions associated with confidence, optimism, fear, anxiety and depression reflect the degree of perceived control available from any source (self, others, or spiritual) at a particular point in time.

Walker (2001: 193-4)

This novel new theory received commendation from eminent Professor of Psychology Ken Wallston (2005). Wallston expresses his envy arising from Walker's new insightful thinking on a truly unifying theory, bringing together the complex constructs of control from across the fields of health psychology. At this time, he was critical that the theory lacked rigorous testing in practice.

Today, this unfortunately remains unaddressed, despite Walker promoting this work in her more recent book on psychology for nurses and the caring professions (Walker, 2012). Despite this weakness in validation, Walker presents an academically recognised unifying theory of control, one that reflects the diversity described in the paradigm of control from the concept of confidence. It is appropriate to suggest synergy and recommend new exploration of this connection as part of further research enquiry.

Discussed above are the four paradigms of confidence and the interconnectedness of these with multiple dimensions of frailty and the wider evidence base relevant to older people living with frailty. This has demonstrated that, on one level, the concept of confidence has strong relational connection with frailty models that would support adoption by a community of frailty care practitioners. However, this is unlikely to happen in a crowded space of competing models and concepts in this world. Therefore, on this level, there is a risk that this conceptual construct of confidence only receives acknowledgement and never drives impactful change.

It is important that this newly created concept of confidence operates on a new level, that gives it scope to influence new ways of working and of service delivery that produces positive outcomes for older people. The next section of this discussion chapter argues this point and moves forward, in a pragmatic way, to translate this new knowledge into practice.

Pragmatic application

Creswell states that a pragmatic researcher takes in multiple perspectives, across the quantitative as well as the qualitative paradigms of research, looking at *the what and how to research based on its intended consequences*.

(Creswell, 2007: 10)

The social constructivist's worldview, adopting interpretivism, has aimed to make sense and meaning about the world (Creswell, 2007: 23). It does, however, become important to move forward and consider the application and implications of this new knowledge for practice, research and education. The next section of this chapter starts by setting the new concept of confidence within the current health and social policy context before going on to explore the pragmatic implications of the concept of confidence, within this context, for practice, research and education. It contains practical illustrations of where the concept could be most impactful.

Health and social care policy connections

It has been argued that the frailty accumulation deficit model takes us so far in addressing contemporary globally health needs and demands today (Rahman, 2019). However, the emphasis needs to switch to one that recognises assets and social capital to grow the resilience and capacity to live well with frailty. In the United Kingdom, the political narrative has been changing over recent years, but to use the analogy of turning the super tanker on the high seas, you need many nautical miles (years) to change its direction. In England, it could be argued that it was the NHS National Service Framework for Older Peoples of

2001 (Department of Health, 2001) that signalled the change of direction, in response to the growing older population predictions. This started to promote the virtues of good health in old age. However, it was much later that this national priority for a new Public Health was strengthened through The Health and Social Care Act 2012 (UK Government, 2012). Intermediate care developments were strengthened as this Bill of Parliament was being debated. A refresh of policy direction at this time reinforced this asset building focus and placed confidence promotion amongst its aims:

Intermediate care should also encompass a wider preventative role, aiming to promote confidence building and social inclusion, thus avoiding the need for institutional care or intensive home care at a later date.

(Department of Health, 2009: 11)

In 2009, frailty was only just emerging onto the political scene in the UK and being translated into policy. The 2012 publication of the Silver Book (British Geriatric Society, 2012) drew attention to the frailty syndromes. This presented commissionable standards for urgent and emergency frailty care services, interpreting the evidence-base for practice. More recently the National Institute of Health and Care Excellence connects further confidence to intermediate care service delivery in national guidelines. They recommend that intermediate care practitioners should: ... *build the person's knowledge, skills, resilience and confidence*, and goes on to describe *reablement* (an often social care name preference for intermediate care) as *aiming to help [older people] recover skills and confidence and maximise independence* (National Institute for Health and Care Excellence, 2017: 17)

This evidence base has continued to grow into what we have today and now informs health and social care policy that will shape the next ten years, through the NHS Long Term Plan (NHS England, 2019b).

The NHS Long Term Plan

Published in January 2019, this long-term strategy for the National Health Service in England has very specific ambitions for frailty care services (NHS England, 2019b). It is within this context that future developments of confidence related interventional studies should be shaped.

The NHS Long Term Plan states in its first chapter, *to support people to live well*, that general practitioners will target those with moderate frailty to enable early detection of ill-health and targeted intervention. An example of an intervention is of falls prevention schemes. Away from early intervention and hospital treatment, the NHS Long Term Plan proposes a renewed focus on multidisciplinary acute frailty services in the Emergency Department, assessing and treating through the delivery of comprehensive geriatric assessment. In the second chapter of the Long Term Plan its focus moves to, *more NHS action on prevention and health inequalities*. Here it commits to address demand drivers that it sees as modifiable; providing better community and social care (or intermediate care and rehabilitation services) in *optimal care settings* and *upstream prevention*, supporting self-management strategies (NHS England, 2019b: 33).

The concept of confidence has presence across all of these developments, from falls clinics, to comprehensive geriatric assessment in a variety of care settings and on to self-management programmes. In terms of healthcare policy,

self-care and self-management are seen as the same and both fundamentally connected to the NHS patient activation programme (NHS England, 2019a). Patient Activation Measures can be used to reduce health inequalities, promote self-management and deliver outcomes-based care (Hibbard and Gilbert, 2014). Older people living with frailty are a cohort of the population with a high expectancy to be self-managing their health and healthcare. Recent research from the Netherlands (Overbeek et al., 2018), reports low levels of activation in this population, which may not be a surprise as the Short Form used to assess such motivation (Hibbard et al., 2005) was validated by 2% of the oldest-old in the population (compared to 38% from the age group 45-54). This raises questions about its validity and its ability to draw any conclusion to its usefulness when engaging the oldest-old. Secondly, this activation measurement tool references Albert Bandura's self-efficacy work in its development of the 13 questions, six are direct confidence judgment statements to be ranked, for example:

I am confident that I can take actions that will help prevent or minimize some symptoms or problems associated with my health condition

I am confident that I can tell when I need to go get medical care and when I can handle a health problem myself

I am confident I can figure out solutions when new situations or problems arise with my health condition

(Hibbard et al., 2005: 1923)

Questions of validity with a population of older people living with frailty need to be asked, especially taking into account the insights the concept of confidence brings and the position argued in this thesis with regard to Bandura. The Partners in Health scale for older adults has been developed and validated in Holland. This used a diverse range of older participants whose age range was

between 75 and 100 years, mean 81.7 years (Veldman et al., 2017). This asks question with strong synergy to the concept of confidence, for example:

I am able to deal with the consequences of growing older in relation to my social life (for example contact with other people)

I am able to deal with the consequences of growing older in relation to my feelings (such as emotions and spiritual wellbeing)

I am able to deal with the consequences of growing older in relation to my physical activities (for example walking or doing housework)

(Veldman et al., 2017: 604)

There is worry that current healthcare policy, focused on patient activation measures, may be misdirected to a poorly evidenced tool for use with older people living with frailty.

The NHS Plan makes a comment with respect to optimal care settings:

providing better social care and community support to slow the development of older people's frailty. (NHS England, 2019b: 33)

A systematic review of intervention effectiveness in preventing pre-frailty and frailty progression highlighted efficacy for physical exercise programmes, especially those which are community based (Apóstolo et al., 2018). The intervention which has the strongest evidence base of support for positive outcomes of older peoples living with frailty is comprehensive geriatric assessment (Ellis et al., 2017). The opportunity to integrate new knowledge from this concept of confidence into assessment practices with older people and frailty offers research opportunities across the science in gerontological care and treatment (Sheets and Whittington, 2012).

This overview of connections for the concept of confidence to health and social care relevant policy is not comprehensively or exhaustively explored here. It does however connect to a range of areas, either of high national priority or strongly evidenced to be most impactful for older people and for the attention of those practitioners.

Implications for practice

For application of the concept of confidence to practice and continuing to respect the knowledge to action framework, the move from knowledge creation to the action cycle is essential (Graham et al., 2014). Pragmatically, practitioners can adopt the action cycle to translate this new knowledge into practice or to use other quality improvement methodology (NHS England, 2018).

Older people's feedback

Following one of the qualitative interviews with a healthcare professional who found discussing confidence issues with older people to be useful in terms of therapy decisions, the new conceptual model for confidence was explored further with several older people who had also been research participants. Feedback from them indicated that the research interview had allowed them the opportunity to rethink their attitudes to confidence and to discharge. They felt the conversation they had with the researcher (the recorded interview) boosted their confidence by actually preparing them for discharge. The idea of striking up a confidence conversation has now been used by the researcher several times in practice to engage older people in 'planning for discharge conversations'. Reflecting with them on their confidence with regard to their

current lived situation, and formulating their feedback into the dynamic representation of the concept of confidence, sometimes sketching it out, has enabled the further identification of aspects of social connections, fear and independence in these conversations. It has also been possible to think (or visualise) about how the levels of control is perceived by older people personally. The model enables clinicians to more easily visualise the person on the continuum of frailty (resilience and vulnerability). This process has also facilitated the identification of potential and actual assets and deficits, which start to guide ideas about the actions needed to shift their confidence situation. These practice-based explorations have provided further valuable insight into beginning to understand how this concept can become embedded into everyday use by practitioners in frailty care and in intermediate care settings.

Knowledge to action: action cycle

Taking this a step further, the plan is to develop a service based intervention using the action cycle of Graham et al. (2014) framework, see Table 26

This illustration of a possible plan (Table 26) aligns strongly with and responds to *optimising care services* for older people with frailty in intermediate care, rehabilitation services, and falls *clinics* as required by the NHS Long Term Plan (NHS England, 2019b).

Other ideas can be developed for *upstream prevention* and the exploration of how the concept of confidence, if embedded within self-management programmes, can be optimised.

Table 26: example of how the action cycle of the knowledge to action framework could be utilised to apply a service based change adopting the concept of confidence.

<p>Identify the Problem: Intermediate care services exist to help older people recover skills and confidence and maximise independence. The idea that confidence is central to this articulate the problem question: <i>How can this service adopt the new concept of confidence to fulfil the central aim of our service.</i></p> <p>Adapt knowledge to local context: Our service provides inpatient reablement to older, frail population stepping up to supportive care from the community or stepping out of acute hospital services, as a half-way house to support ultimate discharge home. Confidence is often heard in this care setting but until now no structured or co-ordinated response occurs. The idea of having a structured conversation about confidence early in a patient stay warrants further exploration.</p> <p>Assess barriers to knowledge use: The care team are currently unfamiliarity with concept of confidence and require resources and facilitated knowledge development sessions to explore its meaning and understanding.</p> <p>Select and tailor interventions: The idea of having a semi-structured confidence conversation is the starting point for this change. The team will start by structuring how such a conversation should be undertaken. They will consider what information could be provided for the older person to set this conversation into some context; what other resources would be useful e.g. notice boards with further information about the paradigms of confidence in the clinical area; and how measuring impact of confidence conversations could start.</p> <p>Monitor knowledge use: A process of continuously gathering ideas and feedback on the adoption of confidence conversation will be required to evaluate and adjust adoption approaches over time. Regular reviews of team understanding of the concept would be checked.</p> <p>Evaluate outcomes: structured team reviews would be scheduled to evaluate adoption and assess its value for the older person (review outcome measures) and for the team. Overtime evaluation of developing measures themselves could be considered.</p> <p>Sustain knowledge use: Continued regular review of team understanding of the concept, peer-reviews and case presentations would aid consistency in knowledge use in practice. Data collection methods would need exploring.</p> <p>Review knowledge: There is importance seen in formally recording and reporting the adoption process and how the concept of confidence informs practice innovation in response.</p>
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Other practice-based opportunities to utilise the concept include:

- Exploitation within established comprehensive geriatric assessment frameworks used in practice. Here, the framing of confidence conversations would be a critical starting point to open up exploration of what may matter most to that older person, thus better identifying the most impactful problems requiring action.
- Connecting them to patient activation measure interventions – the so *what* response to the outcome of their use - as these are currently triggered through confidence-based questions.

Implications for research

Significant post-doctoral research opportunities are ready to explore. Implications for research currently fall in to three main areas: confidence measurement; interventional study development; and theory development. A proposed post-doctoral plan to progress this research journey is illustrated in Figure 25. These ideas are explored in detail in this section.

Confidence measurement

Confidence is a word that can often be dismissed since, as Bandura would say, it is a colloquial, nuance word. This research study's findings has, importantly, raised its status as a credible force in the lives of older people. Quantifying this word (concept) becomes a key aim moving forward.

A two-stage approach has been developed to progress this objective of creating a measure for confidence.

Post-doctoral Study	Stages	Study Description	Methodology	Knowledge to Action Framework Action Cycle
	Description development and consensus	Development on confidence measurement descriptions with older people living with frailty	Delphi method	
	Instrument development	Validation of a concept measurement tool based on confidence statements	Factor analysis	
	Interventional study phase	Feasibility study exploring confidence measurement in intermediate care and the impact of targeted healthcare professional delivered 'confidence conversations'	Co-produced mixed method study	
	Theory development	Statement and theory development	Walker and Avant method	

Figure 25: Proposed post-doctoral plans for the concept of confidence.

The first stage would to develop consensus over phrases and statements that can be judged by older people living with frailty as relevant to their experiences of confidence. This would need to reflect a continuum, as the concept recognises that all four paradigms have fluidity between a positive confidence and a negatively experience state. These should be built on the attributes extracted from phenomenological enquiry and could draw on those from the unified theory of control (Walker, 2001) such as hopelessness, uncertainty, dependency and support. Delphi method (Grime and Wright, 2016) would be deployed to seek strong agreement across these phrases and statements. Rather than using the traditional 'professional' expert group to formulate consensus, co-production approaches through the establishment of an expert group consisting of older people living with frailty, would be utilised. Clearly significant considerations around heterogeneity of an expert group of older people living with frailty would need to be taken to bring validity to the outcome (Keeney et al., 2001).

Instrument development would form the second stage of confidence measurement and follow established scale development (DeVellis, 2016, Morgado et al., 2017) and factor analysis methodology (Watson and Thompson, 2006, Pett et al., 2003). A measure for this concept of confidence would enable practice-based interventional studies to evolve.

Interventional study development

Connected to healthcare professionals' feedback in the phenomenological enquiry, which indicated that there is a benefit to older people in raising the question and talking about the notion of confidence when in post-acute care situations, there is a need for intervention development. In some cases conversations were therapeutic and useful in overcoming barriers and challenges to personal goals, including planning for the transition to discharge home. The idea of the confidence conversation is described above (implication for practice section) and has been tentatively explored, albeit in a limited way. This now warrants further exploration and a future research study is possible, adopting an approach that is similar to that described in Table 26. An alternative to using the knowledge to action framework could be the evidence based co-designed approach (Green et al., 2020), which would be helpful in securing wider engagement of those affected by frailty to get involved in quality improvement or clinical research. Working in partnership with older people and healthcare professionals would offer the best insight to identifying the best routes for the concept of confidence into practice change (INVOLVE, 2019). This would grow and strengthen the evidence base of the conceptual model and advance it towards a more *mature* stage (Morse et al., 1996: 269).

However, as Green et al. (2020) highlight, one significant barrier to success would be the difficulties in engaging vulnerable participants and cohort retention, both factors experienced in this study.

Confidence conversations in practice settings present a realistic option for an interventional research study, as too would be a design that one connects the new conceptual model to old-age appropriate activation measures, for example the Partners in Health scale for older adults developed by Veldman et al. (2017), as synergy has already been recognised. Opportunity exists to construct interventional ideas with older people and healthcare professionals to optimise self-management. The final area identified for research and further scholarly activity is in the area of theory development.

Theory development

There are significant academic study opportunities to position this new knowledge within other conceptual frameworks that this thesis highlights, which have the potential to enlighten practice and improve outcomes for older people. These include: resilience, self-confidence, self-care, vulnerability, knowledge, locus of control (Milte et al., 2015), and the unifying concept of control (Walker, 2001). These would assist in *statement* development and allow the conceptual framework of confidence to become a fully formed theoretical construct (Walker and Avant, 2014). Walker and Avant (2014: 59-60) describe concepts as the building blocks of theory development. They support *statement* developments that position concepts within theory, in either relational, nonrelational or existence ways. To illustrate the connection of different concepts, Figure 26 illustrates the prospect of considering the concept of confidence alongside other conceptual ideas related to confidence.

Here, looking at cross cutting concepts of social isolation and loneliness, which this thesis highlighted as playing a significant role in many older persons' lives (and confidence), it sits close to the vulnerable end of frailty continuum. As the phenomenological enquiry exposed, social isolation and loneliness interrelate with social connectedness, fear and independence in unique ways.

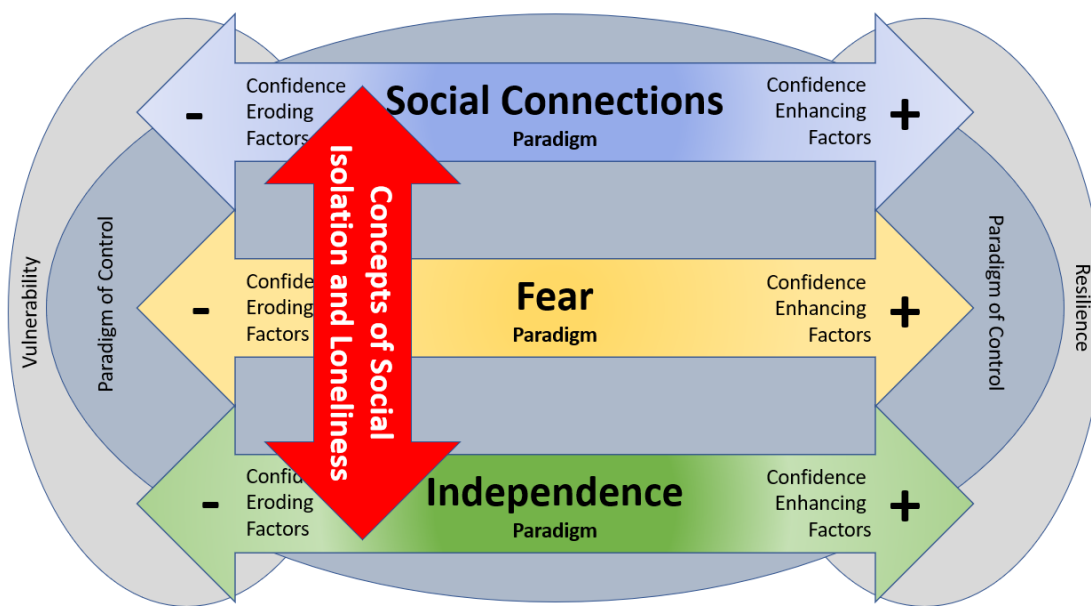


Figure 26: Illustration of the new concept of confidence and here considering the connection to the concepts of social isolation and loneliness

Analysing and interpreting these connections would generate new theory-generating statements that would position this new concept against other established concepts, thereby showing its unique relationality. This not only promotes this new concept, but provides further insightful meaning and understanding further growing its level of maturity (Morse et al., 1996).

Implications for education

This thesis has highlighted from the phenomenological enquiry, the impact of healthcare staff on patient confidence, which played an important role in the emerging understanding of confidence, particularly related to the paradigm of fear. Jonasson and Berterö (2012) research on the importance of *approaching* older people to support self-determination and self-confidence, mirrors many elements in the concept analysis. Under-graduate and registered practitioners would benefit from understanding more about both.

Researcher-led dissemination of findings

The phenomenological interviews highlighted the utter fear some older people experience lying in bed at night, brought on by worrying about the competency and confidence of their carers. This made a significant impact on the research findings' implications and led to conversations with senior ward leaders about the experiences of such older people and the effect it personally has had on the researcher. By trying to understand more, on a professional level, these conversations have been insightful and often problem solving. Many solutions start with education for staff, but often reach beyond this to ward culture (National Institute for Health Research, 2019). This takes further exploration into the realm of research an opportunity again.

Significant time has been spent sharing findings presented within this thesis with others, including: groups of undergraduate nursing students, registered nurses and medical staff and with multiprofessional post-registration preceptees. Synthesising the phenomenological data has resulted in truly evocative stories of these fearful experiences of not having the confidence in staff attending them. These can be combined with the ideas from the

approaching older people work of Jonasson and Berterö (2012), which highlighted confidence connecting themes of: being addressed and receiving respect desiring to participate (both social connectedness linked); increasing self-determination (independence linked); and gaining self-confidence (independence linked in the positive and fear linked in the negative). They form simple ways of promoting easy to grasp concepts, which draw attention to a more immediate concern. Dissemination of this evocative lived experience material from the research awakened colleagues awareness of how older people may experience confidence loss through the fear of non-confident staff. It creates the connection with the lived experience that van Manen writes about. These education sessions have been received well, acknowledging and highlighting in some way a known problem, but one that had not received professional attention in practice; it is needed to positively impact on older people. Such examples of how the researcher has adopted the conceptual model in practice are presented in the hope that they give further insight into how the concept of confidence can be used in practice and opens up ideas for wider educational impact.

Storytelling

Storytelling is a powerful way of communicating such a message, *stories are an entry point to understanding a different experience of the world's* (The Health Foundation, 2016). The evocative narratives of the four paradigms, indeed the seventeen individual interview analyses offer a variety of material that can be used for education and storytelling purposes. Numerous other avenues also exist to disseminate these findings, such as progressing academic publications

in peer-reviewed and professional journals, poster presentations, clinical meetings and within academic institutions by influencing their research informed teaching programmes (Healey, 2005) to nurture and empower future healthcare professionals.

This section has explored practical opportunities and potential implications for the concept of confidence across practice, research and educational domains. This chapter finally moves now to discuss the study's overall strengths and limitations.

Study appraisal and evaluation of trustworthiness

The study's phenomenological enquiry is critiqued here against the van Manen (2014) criteria before a wider discussion on the overall study's trustworthiness across the four conditions set out by Lincoln and Guba (1985).

van Manen set out evaluation criteria to appraise phenomenological studies (van Manen, 2014: 355-6). The headings described in the methods chapter (Table 12) structure an honest appraisal of this study's phenomenological enquiry.

Appraisal of the phenomenological enquiry

Heuristic questioning and **Descriptive richness** – each of the four paradigms are summarised by a descriptive explanation (Tables 19, 20, 21, 22). These are evocatively written statements to describe the essential themes drawn from the

incidental themes and seventeen individuals' interview analysis. It is suggested that there is strong representation and indeed a wonderment (the heuristic epoché) of confidence exposed, from recognisable experiential material in these concluding statements.

Interpretive depth – Here van Manen expects a reported study to go beyond the taken-for-granted understanding of everyday life. The powerful paradigm of control is drawn out of the phenomenological enquiry. This reaches beyond the conceptual analysis' initial exposure in understanding confidence. The paradigm's rich description; from the natural belief individuals describe they possess, to its vulnerability and fragility in the social bonds older people hold with families or with the gatekeepers of care. Control's interaction with the other paradigms, as discussed above in this chapter, reflects a huge complex world of ideas, theory and conjecture. Responding to this, this enquiry presents an interpretive description respectful of this complexity and offers a practical portrayal of control's intrinsic and extrinsic nature that are most impactful to older people.

Distinctive rigor – there has been an openness, throughout this whole study, to a transparency of thought and reflection. A heuristic approach has been adopted, that enables learning to grow and inform research rigor, both of which have contributed to the emergence of a meaningful understanding of confidence from these lived experiences.

Strong and addressive meaning – it is hoped and believed that the narratives presented on the four paradigms 'speak' to the reader, the practitioner working with older people. In sharing the texts, practitioners report they can relate the

narrative to people in their care immediately. This has demonstrated its addressive meaning.

Experiential awakening – as mentioned above, the paradigms' words become relatable to and conversant with practitioners. Of course, this could be further reviewed, revised and rewritten to add additional clarity. However, those presented have emerged with traceable paths back to the original lived experience and to the conversation of seventeen older people living with frailty.

Inceptual epiphany – here van Manen searches for a deeper and original insight. In line with all of the above, a subjectivity in such analysis exists. It will always be for the reader to make the final appraisal. It is important to note that this concept of confidence, brought to life through the lived experiences of older people living with frailty, gives the very first comprehensive understanding of meaning in this context. Reaching for the lived experience has enabled a deep search for understanding. This is hopefully expressed in the study's findings and seen as original, as argued above. For now, this thesis is testament to the extensive search undertaken to find these unique lived experiences to create new knowledge.

Trustworthiness criteria are now individually introduced, followed by a discussion in relation to this thesis.

Trustworthiness of the whole qualitative study

Trustworthiness is a concept established on four appraisable criteria: credibility, dependability, transferability and confirmability (Lincoln and Guba, 1985).

Credibility – stems from the positivist tradition of justifying internal validity, claims about cause and effect. Lincoln and Guba (1986) set out expectations of the qualitative researcher to demonstrate research credibility across several areas, such as prolonged engagement with the phenomena; persistent and in depth observation; triangulation and cross checking of data; independent peer debriefing, negative case analysis and member checking. This thesis has demonstrated undeniably prolonged engagement and persistent observations in seeking meaning and understanding of confidence from this unique perspective of older people living with frailty. The staged study enables congruity with the knowledge creation framework of Graham et al. (2006), where knowledge is developed and tailored in a logical manor to an endpoint suitable for practice. Methodological justification for each stage of this exploration for meaning and understanding has been argued. The ultimate study's findings were drawn together with method triangulation. This demonstrated convergence (Mathison, 1988) across the findings. Clear and accurate presentation of participant perspectives have been given (Noble and Smith, 2015). The peer-debriefing criteria has been met through academic supervision of the research. Here a reflective journal was maintained and discussions arising from reflections were recorded as part of the academic progress record. Additionally, *inquirer honesty* (Lincoln and Guba, 1986: 77) has been provided by engaging other experts in the field of older peoples' and frailty care, in reading and reviewing interpretive analysis findings from the three studies. Negative case analysis, in the sense of searching for negative incidences of the phenomena, have on one level naturally occurred as part of the lived experience enquiry. Here negative antecedent and consequences of confidence were exposed. Additionally, it can

be argued that negative case finding has been judged with respect to the continuous tension between confidence and self-efficacy, ruminated on throughout this study. Finally, member checking has been conducted. However, it was disappointing that overall, only two participants responded to the opportunity to feedback on the findings from the phenomenological enquiry. For some participants engaging in feedback came 21 months following their interview, which would in all likelihood, have affected returns. However, in the responses received there was a recognition of the experience of confidence. In addition to this final member checking, a built-in element of testing and retesting of the emerging themes was adopted into the interviews as they progressed, although the researcher, at times, questioned how these may inhibit or disinhibit pre-conscious extraction of lived experience. It was felt a useful technique to build the idea of consensus around the emerging themes and assisted in the testing of saturation.

Transferability – stemming from the positivists criteria of generalisability.

Qualitative research calls for thick rich description to tell the research story and findings to others about how applicable transferability is. It is believed that these findings have this applicability. It is useful to recognise limitations that need to be considered. Despite being successful in reaching and hearing the voices of the oldest old, with a variety of levels of lived frailty, the phenomenological enquiry sample was drawn from a single county in the most south-west peninsular of England, a location noted for its challenging rurality, isolation and levels of deprivation. Many participants were drawn from some of England's 10% of the most deprived neighbourhoods based on the Index of Multiple Deprivation 2015 (Cornwall Council, 2015). Here there are also a recognised low-level of Black and Asian Minority Ethnic groups.

The study was conducted with those in the intermediate tier of services between acute hospital services and primary care (Department of Health, 2009).

However, in the conversation with older people participants, they spoke of confidence across a wider range of settings where their confidence became a lived experience. This study reports on a period in time with a population of older people with a similar historical perspective and wider-world lived experience, this reflects the temporal nature of our being. Our oldest-old will move on, to be superseded by a new population of oldest-old, with a different world view and experience. This concept of confidence will require retesting for continuing relevance.

It is hoped that rich, thick description of the concept has not been spared in reporting this concept of confidence.

Dependability – aims to demonstrate that the findings are consistent and could be repeated. The auditability of the research process enables a dependability judgement to be made (Lincoln and Guba, 1986). From the outset, qualitative research methods appropriate to the focus of the research question were selected. For example the ambition to meta-synthesise the qualitative data relating to older peoples' experiences of confidence, adopted the established evidence-based approach using the Joanna Briggs Institute System for Unified Management, Assessment and Review of Information (Lockwood et al., 2017, Lockwood et al., 2015). This software-based system supports rigorous systematic analysis, is conducted with a peer-reviewer (supporting credibility), and can be independently evaluated and replicated if required. In the concept analysis, extracted attributable confidence data were made available in a

published supplementary table (Appendix 2) to allow judgement and if required independent replication of the analysis. Finally, Appendix 3 of this thesis contains comprehensive detail of the primary phenomenological analysis of interviews that demonstrate a high-level of reflexivity. With regard to the methodological approach taken, van Manen would argue how Husserl would never accept the specific nature of this study's focus on older people living with frailty. Rather, he would be interested in the higher aspiration of understanding the human experience of confidence first, then to move on and describe the understanding of what confidence is like for these older people living with frailty. You can understand the critics of van Manen in part, as presenting his agogical approach to the phenomenology of practice, there is a blur between descriptive and interpretive philosophical paradigms. This self-aware and reflective attitude was demonstrated and illustrated through sharing analysis extracts and captured written study records, and reflecting on these potential influences and bias.

Although no formal external audit of the study was conducted, these data have been shared for peer-review. The phenomenological enquiry received with ethical approval and the wider study was overseen by academic supervisors and research sponsors.

Confirmability - is the degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest. Lincoln and Guba (1986) suggest a confirmability judgement can be made on the auditability of the final product, constructed from all data captured. It is inevitable that biases and prejudices can enter into the interpretive analysis. However strategies can be adopted to minimise these (Noble and Smith, 2015).

Many have been built into this research study design and in its reporting here. The epistemic stance of the researcher has been clearly stated in this thesis. This supports the reader's judgment of motivation and personal interest. Sampling of the literature was comprehensive. The systematic review study drew on the expertise of a specialist librarian, the phenomenological enquiry sampling was purposeful, so open to bias, but this was reduced by separation of the researcher from patient selection; using of confidence as a trigger word. The study design changed to interview older people participants in hospital as follow-up access was identified as a problem, this may have impacted on lived experience memories. The first five of the seventeen older people participants were interviewed at home, the subsequent interviews were all in hospital settings. Openness in post-interview reflections often challenged feeling of reaching the participants lived experience from which the data was interpreted. The use of the reflective diary and regular supervision minimised this as far as possible.

It is believed here and across the trustworthiness criteria a strong confirmability statement can be made with regard to study conduct and its outcome.

Study strengths and limitations

This is the opportunity to reflect back and acknowledge the achievements and strengths, but also any missed opportunities and limitations of this research journey. Research strengths and weaknesses are presented for reasons of transparency, but also to ensure learning is taken forward as lessons to inform future research activities. Table 27 presents a summary of the studies'

strengths and limitations. This chapter concludes with personal reflections on these.

Reflecting back: strengths

Two peer reviewed papers comprising of original research have been published during this study period (linked to study stages 1 and 2). These have substantially contributed to meeting a criterion for a doctoral award:

interpretation of new knowledge, through original research or other advanced scholarship, of a quality to satisfy peer review, extend the forefront of the discipline, and merit publication. (The Quality Assurance Agency for Higher Education, 2011)

Each of these studies required the personal growth of new knowledge and understanding and acquisition of skills to apply these faithfully. It is an achievement to have these works acknowledged and published.

Table 27: Table summarising overall study strengths and limitations.

Strengths	Limitations
Two peer-review publications making key contributions to the existing evidence base	<p>Acknowledged study limitations in the green manuscripts presented in this thesis all remain valid.</p> <p>Systematic Review</p> <ul style="list-style-type: none"> • Very few articles were metasynthesised • Difficulties identifying frailty in articles • Limited to English language articles <p>Concept Analysis</p> <ul style="list-style-type: none"> • Search limited to three large bibliographical database • Exclusion of articles connected to self-efficacy and balance confidence scales • Limited to English language articles <p><i>continued</i></p>

A honest and faithful commitment to van Manen's agological approach to phenomenology has been made.	Member/participant checking of the phenomenological enquiry's findings could have been stronger.
The concept of confidence's triangulation was strengthened by the conclusions of the phenomenological enquiry creating a final meaningful concept of confidence relevant and transferable to practice.	Poor ethnic diversity of the participant sample of the phenomenological enquiry is unknown.
Rare new voices of the oldest-old in our communities have been added to the research literature through the phenomenological enquiry. This study adds depth and details which were previously missing.	Carers contribution to the conceptual development was limited due to recruitment challenges.
	The stance taken regarding Bandura's Self-Efficacy work may be questioned, although justification has been robustly given.

The second of the strengths centres on the phenomenological enquiry. This, in many ways, presented the formative research learning experience and greatest reward, as the voices of older people came to life guided by van Manen's approach to phenomenology. Steps taken to conduct the study, oversee its governance and deliver on reporting responsibilities were informative, cementing new knowledge in research conduct. The outcome was the most rewarding, one that truly gave, to the very best of my ability, a most honest and faithful methodological interpretation of van Manen's agological approach to phenomenology. It needs to be acknowledged that phenomenology is very much an art form, and not a science (in van Manen's worldview). Many may interpret his worldview differently from mine, and rightly so for this difference

needs to be celebrated (another of van Manen's worldviews) and judged in the open and transparent way it is presented here. Readers familiar with van Manen's works will hopefully read and reflect on the subtle influence and impression he has made on me (included throughout this thesis), and yet others will pass over these but hopefully still recognise a true phenomenological faithfulness that can be evaluated against evaluation criteria to appraise phenomenological studies (van Manen, 2014: 355-6 for example).

The third strength is drawn from the conclusions of the phenomenological enquiry; those powerful and evocative narratives of the seventeen older peoples' interpretations of lived experiences of confidence. These informed the subsequent narratives for the four dimensions of confidence, which formed the final essential themes. These made a major impact on the outcome of method triangulation, and were weighted strongly to influence the final concepts reconstruction. The narratives associated with the new paradigms of confidence remained the same, as they were strongly grounded in the lived experience of confidence but the new titles evoke a stronger connection to the essential themes from which they emerged. These, along with the complete revision of the final concept model, delivers a product that has the potential to be directly transferable to practice. Already it has demonstrated a synergy to older people and to practitioners in older people clinical care settings. A range of future opportunities have also been highlighted.

Finally, a strength that cannot be underestimated, originates from the seventeen older people who participated in this study. In light of the low number of voices extracted from the papers included in the systematic review, the synthesised findings were judged as contributing just weak evidence to the

method triangulation. This weakness has now been rebalanced because this thesis, and planned future publications, add significant depth and details as well as previously unheard new voices to the literature, strengthening this contribution of new knowledge of confidence to the evidence base for practice, policy and education.

Reflecting back: limitations

The first limitation in the summary table above (Table 27) acknowledges each of the first two studies' limitations highlighted in the green final manuscripts of Chapters 3 and 4. These focus on potentially missing voices, through the title and abstract stage of narrowing down publications to review; and the recognition that frailty identification was difficult, suggesting the findings were drawn from a pre-frailty, albeit vulnerable population; Another limitation from the systematic review was the restriction of a care setting that focused on post-acute and intermediate care. This latter limitation was articulated in the review protocol but now, in hindsight, literature drawn from a non-restricted range of settings could have been included and synthesised. Finally, common to both studies reported in chapters three and four, were limitations in the database searches; the concept analysis was limited to three large bibliographical sources and only included English language material, and now additional material, post 2016 and 2018 respectively, could now influence the results.

The second limitation has already been reflected on, that of limited participant or member checking of the phenomenological enquiry's outcome. This could have been strengthened through more timeliness of returns, and greater engagement to inform participants of the delay. This was considered, but ethical

approval for more continuous contact was not in place. This would be useful to include in future study designs if delays in disseminating findings were anticipated. Other opportunities to strengthen the phenomenological study include the idea that a wider recruitment pool, involving more post-acute care areas and community intermediate care teams recruiting would have shrunk considerably the recruitment timescales. This may also have attracted more carer participants to the study. A further factor that could have strengthened the study would have been to have had an active Patient and Public Involvement and Engagement (PPIE) group operating throughout the doctoral programme. It is important to reflect here that the systematic review acknowledges the input of a PPIE group in recognising confidence in the final findings. This was not well cited in the final publication, due to the constraints of the journal's editorial guide. In fact, this PPIE group was recruited as part of the researcher's internship, before the doctoral study period started. Six members of a small group contributed to the systematic review's development and focus, advocating strongly the need to ensure the voices of older people were heard from the literature. The length of time that research takes is mentioned above, as here too its toll is witnessed. Time, for older people living with frailty, some with very severe frailty, is very limited. Over the course of the systematic review, PPIE group members dropped away, with some communicating changes in health status or in personal circumstances as reasons to drop out, whilst others just fell silent. In hindsight, the PPIE group should have been regularly refreshed with new, older people living with frailty recruited. This group would then have played an important part near the end of the phenomenological analysis to strengthen member checking. The PPIE group would have significantly enhanced confirmability. This lesson has been learnt, and already

acted upon in preparing for the next stage of post-doctoral research with the concept of confidence. Here a call to the community for the formation of a collaborating group of older people living with frailty, planning for group longevity will be prioritised.

Reinforcing the reality that phenomenology is not generalisable, this third study limitation acknowledges that the unique study design, building evidence on evidence to generate new knowledge and a final product (Graham et al., 2006) may be weakened by the phenomenological enquiry's lack of participant diversity. It needs simply to be acknowledged and give opportunity for the concept to be strengthened through validation with a more diverse population. What remains unknown, is the full diversity profiles of the reviewed studies, particularly those include in the concept analysis that initially shaped the construct of confidence.

The final study limitation is that of the impact of the stance taken in this thesis with regard to self-efficacy and the interpretation of the statement on confidence by Bandura. This could be questioned although, as best presented earlier in this chapter, within the discussion on the paradigm of fear, without this clear separation, this now unique concept of confidence would not exist and its future impact would not be realised.

Summary

This chapter has discussed the wide ranging connections to contemporary frailty models and practice based interventions and this new concept of confidence, presented the perspective of older people living with frailty.

Consideration of the implications and impact on practice, future research and education have been set out. The final section of this chapter appraised the strengths and limitations of the study and reflects on lessons learnt. The final chapter follows, presenting the concluding aspects of this thesis.

CHAPTER 9

THE CONCEPT OF CONFIDENCE OF OLDER PEOPLE LIVING WITH FRAILTY: THE FINAL SYNOPSIS

***“No matter what people tell you,
words and ideas can change the world.”***

(Robin Williams)

This thesis has highlighted the changing world we live in, one in which we see a growing population of older people living with frailty. These simple words of confidence’s meaning and understanding will lead to impactful new ideas to change the individual worlds of these older people.

Answering the research question

The aim of this thesis has been to contribute unique new knowledge related to what confidence may mean to a population of older people living with frailty and begin to explore practical opportunities in its use to support older people to grow old with optimal physical health and mental well-being.

The overall aim was:

To explore and develop a concept of confidence in the context of older people living with frailty and to consider implications for practice.

The four objectives underpinning this aim were:

1. To meta-aggregate qualitative evidence relating to the meaning and understanding of confidence experienced by older people living with frailty.
2. To synthesise contemporary evidence to produce a construct of what 'confidence' is, in the context of older people living with frailty.
3. To conduct a phenomenological enquiry to understand the lived experience of the phenomena of confidence with older people and its contextual relationship with frailty with carers and healthcare professionals
4. To undertake an evaluative review, considering all data collected in the study to create the final concept of confidence; and consider implications for practice and future research.

These objectives neatly formed four novel methodological lines of enquiry that sequentially built upon each other to generated new knowledge within this unique area of discovery. Influenced and shaped by the Knowledge to Action

framework (Graham et al., 2006), these built to construct a credible new concept of confidence that resonates with practitioners and has transferability to practice and practice delivery frameworks. Prior to this research being undertaken, no conceptual framework of confidence existed, despite the terms becoming more and more prominent in English healthcare policy.

In summary this thesis has presented:

Firstly, the original context regarding the notion of confidence was set out in Chapter 1, with a historical perspective of frailty provided in Chapter 2. This chapter gave context to the development of today's contemporary frailty models, within which it was postulated that confidence resides. Rahman described frailty as *a complex and multidimensional state linked to other concepts including multimorbidity, disability, dependency and personal resilience*. (Rahman, 2019: 1). This reinforced a more contemporary view of frailty, one stronger in promoting the importance of building assets (physical, social and mental health relevant assets) to balance against the recognised deficits that arise with increasing age and the onset of frailty syndromes, referred to as balancing resilience and vulnerability. This contextual reference is fundamental to the conceptualisation of confidence that later emerged. The third chapter was constructed around the systematic review of the qualitative literature to directly answer the first objective of the study. This meta-aggregative review found limited evidence of the voices of older people living with frailty speaking of their confidence. However, meta-aggregation of three categories drew an ultimate finding of vulnerability (Underwood et al., 2017), and a unique description in the context of confidence was given. This describes

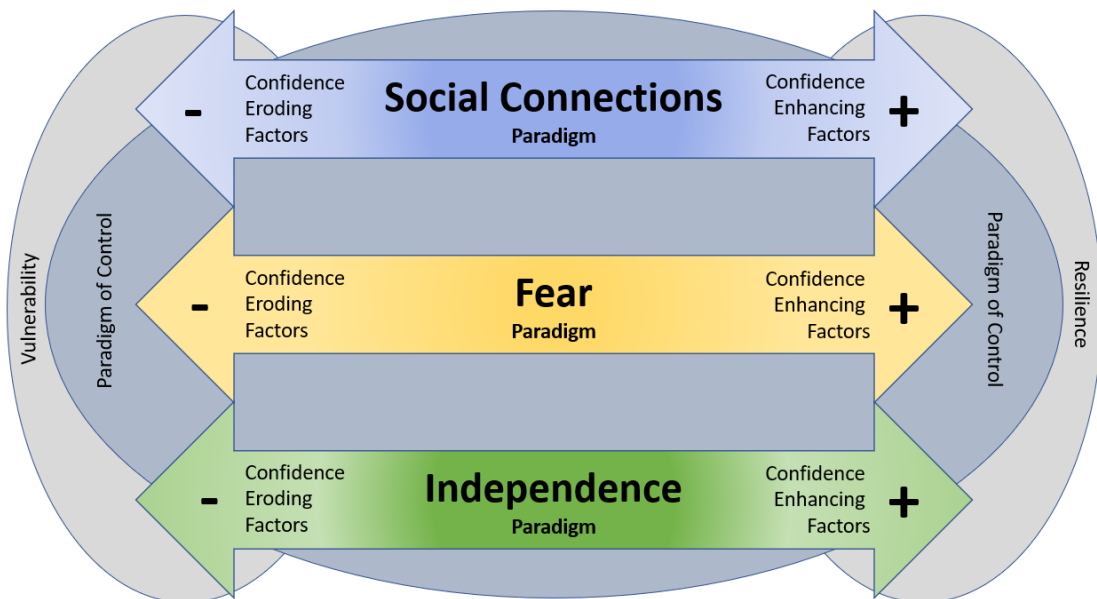
a fragile state of well-being exposing factors that can enhance or erode the older person's confidence. This started to suggest what confidence for older people living with frailty may mean, however evidential weight was weak. Chapter 4 explored a wider literature base around the notion of confidence within this population using established concept creation methodology (Walker and Avant, 2014). A primary concept of confidence was presented in response to the second research objective of this thesis. This concept highlighted a cross-cutting component of control; a domain that directly influences the individual's physical health and mental well-being (across individual physical, psychological and social domains).

The first two stages of the research were conducted in response to the first two objectives, and were seen as important building blocks to a greater understanding of confidence in this older population. The next research objective (3), was addressed and reported in chapters 5 and 6. Chapter 5 presented the key aspects of a participative research design, detailing the methodological approach used to inform the interpretivist phenomenological enquiry. Chapter 6 presented the analyses and phenomenological findings from seventeen unique lived experience narratives of confidence. This evidentially strong and powerful contribution the evidence base, in part influenced by the earlier study stages, shows how new knowledge was exposed through the individually interpreted lived experience interviews and emerged through analyses to the point where four essential themes were created. These were: social connections; fear; independence; and control. The evocative descriptions of these domains of confidence added significant detail, depth and a richness to understanding arising from the earlier conceptual development. Chapter 7 responded to the final research objective (4) and presented the approach

adopted to the analysis of findings from the three studies; that of method triangulation. Findings were weighted and overall a good level convergence was found. Significantly, this triangulation, influenced by the strength of lived experiences from the phenomenological enquiry, transformed the concept of confidence. Chapter 8 presented a discussion that highlighted the unique and original knowledge contribution this conceptual framework gives, exploring its interconnection to other concepts in the world of frailty and contemporary healthcare practice. A pragmatic worldview was taken to explore implications in practice, research and education, some reflecting on how the advantage has already been taken to utilise this new knowledge and explore its translation to practice. A honest reflection of the overall study's strengths and limitations have also been presented. This current chapter now provides a concluding perspective for this comprehensive research study and summarises the unique and original contribution to knowledge that has been made.

The final concept of confidence is drawn together here, pulling the parts and elements illustrated and described throughout the main body of this thesis. This represents the end of point of new knowledge discovery and also the starting point of new knowledge discovery.

THE CONCEPT OF CONFIDENCE



The concept of confidence, through the lens of older people living with frailty, is controlled by a multitude of internal and external factors that can either erode or enhance their confidence. Confidence sits with a continuum of frailty, between resilience and vulnerability and is directly influenced by the individual's perceptions and lived experiences of social connections, of fear factor and of their independence. This dynamic and interdependent concept is receptive to change through targeted interventions to strengthen resilience across these four paradigms.

The interpersonal impact on confidence through social connections with others: a social paradigm

The social connection of others to an older person's confidence is as unique as the individual themselves. This interpersonal connection is relational, it is a social association between them, the significant other in their life and then directly to their confidence. This dimension takes countless forms and characters. It appears as a social bond that forms and shapes their confidence. These social bonds, or connections can be with family; partners, husbands or wives, with daughters and sons, or with siblings and their children. They may be with: friends; with neighbours or carers; with health professionals in hospital or in the community; or with a religious faith and spiritual being.

continued

In turn, these social bonds, these personal, social connections to confidence can be strong or very fragile. In strength the connection with family, friendship and companionship gives confidence, hope and optimism. If this bond to others is broken, either permanently or temporarily; through loss of a spouse or abandonment of friends, or to the fleeting trust held in the carers supporting them, this broken connection leaves a person holding on to a frail confidence; a vulnerable confidence.

The relationship of fear to confidence exposes a powerful and emotive effect: a psychological paradigm

Fear (also referred to as dread, anxiety, fright, panic or worry) is tethered to the confidence for older people living with frailty. Whether triggered by an incapacitating fall, an illness such as delirium or, through the treatment or care received, fear can powerfully erode a person's inner confidence. This fear resides in the person's mind, playing psychological games. For some, they can speak to the confidence inside and try to bargain and rationalise with it, in some convincing way. These internal conversations attempt to overcome fear's ability to wear or tear away at the person's confidence. For others it completely disables their desires, leaving them helpless and hopeless, and for some completely mentally debilitated and depressed. Confidence is consumed by fear.

Physical independence is a stimulus to confidence: a physical paradigm

The determination to be independent is a physical driver for confidence. Confidence's connection to physical functioning is important to maintain. The person's body and its physical strength is important in sustaining their independence and overcome the limitations the person living with frailty increasingly faces in later life. Confidence is often undermined or lost as a result of the physical effects of accident, injury or ailment. Quickly the person's ability to physically look after themselves, to self-care, can be affected. For some, a growing dependency appears to sit beside a fading confidence – an uncomfortable and sometimes painful companion. For others the desire to physically overcome a feeling of frailty, lays witness to a growing confidence.

The control of confidence is fundamental but not always achievable. Control exists at the crux of vulnerability and resilience: a control paradigm

The control an individual has over their confidence is variable.

continued

Some older people living with frailty have a natural belief in the control they have over their confidence. These people often refer to their experience of confidence over their life-course, a confidence that has been shaped, by themselves, but often by others. This confidence carries forward into older age. However, as frailty becomes recognisable in their bodies and minds, the vulnerability of control over their confidence may falter and they become hesitant. This vulnerability is influenced by a reliance on other social, psychological and physical factors. For example, social connections (family, friends, healthcare professionals, neighbours or carers) in older peoples' lives can be control givers or control removers. A strong connection to a social group, to family and friends, can liberate a person's control over a vulnerable confidence. The opposite sees loneliness and isolation limiting control and removing their resilience and then their confidence. Mental or psychological control over matters of confidence help some people, but mental fragility removes this control quickly and can rapidly take confidence away from their grasp. Regarding physical factors and independence, strength building and activities like goal-planning and target setting to regain mobility and self-care capabilities help gives control back. For others their control over confidence in physical matters will always be a struggle, overwhelmingly influenced by complex health problems, impairments and disabilities. There is a constant tension between the person's internal control over their confidence and external control or controlling factors that affect their inner confidence.

Originality of this thesis

The originality of this thesis is informed by the voices of the seventeen older people living with frailty that contributed to a key part of this study. Before they volunteered to participate and speak out and share their experiences of confidence, very little was known. There were scant glimpses of what it might mean, but following the phenomenological inquiry their unique vocal contributions gave individuality and originality to this thesis. Their articulations strengthen the final concept model and bring a resonance that practitioners will hear and concur with in practice.

The importance of confidence and the impact of this concept

This section concludes by summarising what is known about confidence in the context of the people it affects, their carers and those duty bound to support them. This research journey has been so important because of these very peoples who volunteered to participate, bringing to life previously unexplored expressions of, often, confidence loss, which carries so many impactful implications.

Alongside the concept's significance, its impact is considered here too. Impact relates to the effect this research into the concept of confidence should now have, from the perspectives of individual older people to society-wide impact (Greenhalgh et al., 2016). Considerations on the implications for practice and future research are finally postulated.

The importance of confidence for older people and for their carers

For older people living with frailty, confidence is important, for its impact, for what it can do, as much as for what it cannot do.

“I know I can do it, but then I am scared to do it ...I have lost my confidence.” (Participant 02)

The impact of confidence is as individual as each older person. When confidence is present, much can be accomplished, but as we have seen, when diminished the impact can be devastating. The confidence-level of older people living with frailty is significant and tangible for their carers too. Although this research was unable to capture many of their voices, it is clear that the

confidence of the person they care can have a parallel impact on them. This transfers over to their own personal health and well-being:

“I could see a real fall in her confidence ...she was [now] so heavily dependent on me, I thought to myself, ‘Oh my god, am I going to be able to keep this up?’ Because I’ve got a family and work [to consider too.]” (Carer Participant 01)

The impact of this new concept for older people and their carers

The study unearthed the devastating effect that confidence loss has on older people: impacting on health and independence; causing social isolation and generating a fear affecting mental well-being, even self-care abilities. The new concept of confidence presents, for the first time, a practical and pragmatic framework that gives tangible meaning and understanding to confidence. The new visual representation of confidence (Figure 20) and supporting description exposes a complex multi-paradigm concept. The practitioner will easily recognise and connect the individual paradigms as they are readily identifiable in confidence exploring conversations with older people. Only now is the essentiality of the concept to older people and their carers simply attainable, thanks to the contributions made by this research. New opportunities exist to explore, with older people and their carers, how they see this concept being most impactful in practical terms. An important starting point is that already experienced by some of the research participants in the study, playing a role in the consideration of their own beliefs and attitudes to their lived confidence situation

A couple [of participants] have said, that once they had spoken to you, they kind of understood more about the difference between fear and confidence ... they have got a grasp of what they were fearful of and gone home with a much more positive outlook. (HCP04, starts line 142)

Further work is needed but early feedback suggests that older people are able to use the conceptual model to explore the connections to their frailty continuum, recognising their assets and deficits to see how it may be possible to manipulate controlling factors to change their experience of confidence. The devastating impact of confidence in its negative form cannot, and should not, be ignored.

The importance of confidence for practice, service providers and wider society

For healthcare professionals, those who often hear the utterance of confidence concerns mentioned in conversations but are then unsure how to respond, this concept of confidence is also targeted at them. It furnishes them with meaning and understanding, generated directly from the lived experiences of older people themselves. It will stimulate new practical ideas and developments to deploy in order to maintain and boost confidence in this oldest-old population.

“... you’re in your house, feeling really miserable. I haven’t got the confidence to go out, and then somebody might call in and say ‘Argh, come on, I’ll come with you’. I’d take the chance and go. That boosts your confidence” (Participant 13)

For service providers, as with the staff they employ, they too must be confidence aware. This is important to voluntary, private and statutory providers of health and social care, who support older people in society. They have much to gain by mobilising preventative actions focused on confidence maintenance and promotion.

“I feel a bit lost and not in control. I just want to get my confidence back” (Participant 15)

This new knowledge has the potential to truly inform policy and programme development across the world-wide healthy-ageing agenda (World Health Organization, 2017).

Importance of this new concept for practice, service providers and wider society

This concept of confidence will contribute to new opportunities in practice, translating this new knowledge into action. It could be discourse changing. One of the most important of these explored in this thesis centre around co-produced work that will help translate these findings into practical solutions. Development of a confidence measurement tool is a priority, so that evaluation of interventional impact can be undertaken. However, early adoption ideas have led to opportunities being identified for *confidence conversations* to become part of everyday practice, including a goal being to embed them within existing comprehensive geriatric assessment frameworks. Services need to use this concept and its narratives to respond to the Government’s challenge, in England, to respond appropriately to the aging population through confidence promoting health and social care provision, within intermediate care and through self-management programmes. This concept of confidence aligns clearly with these policies and therefore has a significant role to play in the delivery of high quality, person-focused health and social care for the foreseeable future.

My personal conclusions

This thesis started with a short personal monologue, my epistemic stance. This chapter's final section finishes with my very personal reflections on this five-year long research journey.

On the research journey

Five years of part-time study has been all encompassing. Every day I have thought about this research, read a little, and , most days I have written a little about this research too. This was the advice of my Director of Nursing who started me of on this journey and, reflecting back, this shared wisdom has been the most practical tip I have received to prepare me for this clinical and academic learning experience. These little bits have mounted up to form a significant body of work. This unique study has epitomised the thoughtful action of the art and science of nursing – my nursing praxis (Burns and Bulman, 2000). The Knowledge to Action framework has been formative, guiding the pragmatic endpoint of a concept of confidence that is transferable to practice and action. The privilege of hearing from the seventeen participants, who generously shared their personal lived experiences will be everlasting. Reading their words in this thesis recalls in my mind each unique encounter. Their voices allowed the creation of the unique and evocative narratives of confidence's paradigms, which I hope will resonate for a long time to come.

This five years has witnessed my transition from novice to competent researcher. At times it has felt overwhelming as I tried to master the complexities, the conflicts and convergences of this vast world of qualitative enquiry, specifically that of philosophies of phenomenology. The texts of Max

van Manen have been a constant companion, enabling enlightenment to new evocative writings skills (what van Manen sees are true phenomenology) to emerge through the discipline of writing and rewriting and rewriting again.

On the emerging concept of confidence

For me, the strongest contribution this thesis gives to advanced scholarly study is the unique voices of older people and the influence they have made on the concept of confidence. Five years ago, at the start point of this journey, there were very few voices that could have informed a construct of confidence. In building the concept, their voices of talked confidence have been be decoded through the paradigms of the social connections, fear, independence and, their relationship to control.

I am proud to have revealed this unique study that presents these extraordinary voices that tell their stories of confidence; one to be shared with others.

On originality of this research

Looking to originality I am aware this thesis is judged on advanced scholarship and its original contribution to new knowledge, some of the key requirements for a doctoral award (Box 2). I believe I have established that this thesis delivers on each of these requirements, with the discovery of new insight into the lived experience of confidence and development of a conceptual framework to influence practice. This was not known of before and now it exists. Peer-review publications have cemented this contemporary area of new knowledge within the literature of frailty care. It is through the lens of older people living with frailty that systematic acquisition of newly acquired evidence and knowledge brings into focus the life worlds that confidence resides. This new knowledge has been developed to shape professional practice, some of my early adoption examples have been shared.

Box 2: Original contribution to knowledge

Doctoral degrees are awarded to students who have demonstrated:

- the creation and interpretation of new knowledge, through original research or other advanced scholarship, of a quality to satisfy peer review, extend the forefront of the discipline, and merit publication
- a systematic acquisition and understanding of a substantial body of knowledge that is at the forefront of an academic discipline or area of professional practice
- the general ability to conceptualise, design and implement a project for the generation of new knowledge, applications or understanding at the forefront of the discipline, and to adjust the project design in the light of unforeseen problems
- a detailed understanding of applicable techniques for research and advanced academic enquiry.

Extract taken from The UK Doctorate publication
(The Quality Assurance Agency for Higher Education, 2011)

This research project had been led from the perspective of a Chief Investigator to obtain data and to extract new knowledge. A range of methodological approaches have been utilised and these complement each other , enabling robust method triangulation to formulate the final product. Adaptation had been necessary, as the concept model changed, informed by the new evidence derived from each phase of the research. This researcher's expertise has also grown as the study progressed. A deeper and richer understanding of multiple research worldviews and methodological approaches have been realised, critiqued and adopted. Finally, my pragmatic research worldview has

particularly opened up the opportunity to take a theoretically developed construct and begin to apply it to identify real-world practice-based, research-based and educational opportunities.

Summary

This thesis has brought the voice, through these words, of the often unheard to the wider world. These voices will now reach out, giving us new insight and simply teach us of confidence's true meaning and understanding:

“... having confidence is saying, ‘I can do it!’ (Participant 22)

This thesis has revealed that confidence is a word that has not been truly understood. Method triangulation has powerfully contributed to consolidating findings, from three qualitative studies, to create a unique concept of confidence from the perspective of older people who live with frailty. This research now raises this concept as an important and real influence in the lives of older people. This new concept of confidence compellingly associates well with frailty models, exposing assets equally as well as deficits. This new concept of confidence now needs empirical referents developing to measure and quantify its impact further, in the lives in which it resides and across new practice-based interventional opportunities. In many ways, the journey of discovery has only just started.

APPENDICES

Appendix 1: Appendices from Chapter 3	319
Appendix 2: Appendices from Chapter 4	339
Appendix 3: Detailed phenomenological analysis of six older participants interviews	377
Appendix 4: Health Research Authority Ethics Approval Letter .	415
Appendix 5: University of Plymouth Ethics Approval Letter	420
Appendix 6: Final correspondence approving the non-substantial protocol amendments	421
Appendix 7: COREQ Checklist (COnsolidated criteria for REporting Qualitative studies)	424
Appendix 8: Illustrations of the four paradigms of confidence ...	426

Appendix 1: Appendices from Chapter 3

Appendix I : Search strategy examples

Database: Medline

Date of search 17/07/15

Platform: OVID via University of Plymouth

mp = title, abstract, original title, name of substance word, subject heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier

1	elder*	mp	200600
2	old*	mp	1061159
3	exp aged/	MeSH	2478965
4	aging/	MeSH	195881
5	1 OR 2 OR 3 OR 4		3394361
6	frail*	mp	14033
7	health status/	MeSH	63382
8	geriatric assessment/	MeSH	19779
9	(geriatric or gerontol*) adj2 assess*	mp	20925
10	quality of life/	MeSH	128885
11	quality adj2 life	mp	220787
12	age factors/	MeSH	390030
13	risk factors/	MeSH	611322
14	sickness impact profile/	MeSH	6410
15	6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14		1218311
16	confiden*	mp	358869
17	exp self concept/	MeSH	76865
18	trust/	MeSH	6391
19	body image/	MeSH	13700
20	emotional intelligence/	MeSH	1046
21	adaptation, psychological	MeSH	77954
22	interpersonal relations/	MeSH	58169
23	self psychology/	MeSH	439
24	behavior/	MeSH	27077
25	health behavior/	MeSH	36776
26	motivation/	MeSH	52194
27	social behavior/	MeSH	38046
28	social desirability/	MeSH	4019
29	social isolation/	MeSH	11383
30	16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29		690653
31	5 AND 15 AND 30		72978
32	age distribution/	MeSH	55647

33	health education/	MeSH	53737
34	health services for the aged/	MeSH	15499
35	"health services needs and demand"/	MeSH	44257
36	social support/	MeSH	54536
37	32 OR 33 OR 34 OR 35 OR 36		216044
38	31 AND 37		6471
39	confidence interval*	mp	273857
40	38 NOT 39		3857
41	limit 40 to (English language and yr="1994 - Current"		3338

Database: CINAHL

Date of search 22/07/15

Platform: EBSCO via University of Plymouth

MH = exact subject heading

N2 = finds the words if they are within two words of each other regardless of order

TX = text word

S1	TX elder*	all text	145982
S2	TX old*	all text	450895
S3	MH Aged+	exploded	533699
S4	MH Aging		32703
S5	S1 OR S2 OR S3 OR S4		880015
S6	TX frail*	all text	21439
S7	MH Frailty syndrome		182
S8	MH Health status		35889
S9	MH Geriatric assessment+	exploded	11933
S10	TX (geriatric or gerontol*) N2 assess*	all text	14625
S11	MH Quality of life		63314
S12	TX quality N2 life	all text	157175
S13	MH Age factors		81569
S14	MH Risk factors		109743
S15	MH Sickness impact profile		1915
S16	S6 OR S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15		375693
S17	TX confiden*	all text	316501
S18	MH Confidence		4609
S19	MH Self concept+	exploded	41022
S20	MH Trust		5886
S21	MH Body image+	exploded	8987
S22	MH Emotional intelligence		1154
S23	MH Adaptation, psychological		21439
S24	MH Interpersonal relations		30614

S25	MH Behavior		13208
S26	MH Health behavior		30764
S27	MH Motivation		22933
S28	MH Social behavior		12410
S29	MH Social isolation		4989
	S17 OR S18 OR S19 OR S20 OR S21		
S30	OR S22 OR S23 OR S24 OR S25 OR		457598
	S26 OR S27 OR S28 OR S29		
S31	S5 AND S16 AND S30		55206
S32	MH Health education		18799
S33	MH Health services for the aged		5164
S34	MH "Health services needs and demand"		16220
S35	S32 OR S33 OR S34		39495
S36	S31 AND S35		1152
S37	TX confidence interval*	all text	183950
S38	S36 NOT S37		799
S39	limit to 1994-2015, English		753

Database: EMBASE

Date of search: 17/08/15

Platform: OVID via University of Plymouth

mp = Title, Original Title, Abstract, Subject Heading, Name of Substance, and Registry Word fields

1	elder*	mp	346505
2	old*	mp	1411870
3	exp aged/		2316311
4	aging/		206326
5	1 or 2 or 3 or 4		3570328
6	frail	mp	13328
7	exp health status/		159071
8	geriatric assessment/		10456
9	(geriatric or gerontol*) adj2 assess*	mp	12624
10	quality of life		291689
11	quality adj2 life	mp	359349
12	age/		412170
13	risk factor/		167977
14	sickness impact profile/		1946
15	6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14		1537001
16	confiden*	mp	419562
17	exp self concept/		144335
18	trust/		7986
19	body image/		16438
20	emotional intelligence/		1388
21	adaptive behavior/		50262

22	human relation/	80025
23	psychoanalytic theory/	12287
24	behavior/	132798
25	health behavior/	48472
26	motivation/	77013
27	social behavior/	67667
28	social desirability/	4067
29	social isolation/	17637
30	16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29	959981
31	5 and 15 and 30	62311
32	age distribution/	107370
33	health education/	83142
34	exp elderly care/	68513
35	health care need/	21035
36	social support/	63877
37	32 or 33 or 34 or 35 or 36	334410
38	31 and 37	7655
39	confidence interval*	313364
40	38 not 39	4873
41	limit 40 to (english language and yr="1994 - Current"	4219

Database: PsychINFO

Date of search: 17/08/15

Platform: Proquest via University of Plymouth

anywhere = searches for terms in all fields

SU = subject

S1	elder*	anywhere	65568
S2	old*	anywhere	1643833
	<i>line S3 deleted due to error</i>		
S4	SU.EXACT ("Aging")		40712
S5	1 or 2 or 4		1656446
S6	frail*	anywhere	3469
S7	SU.EXACT ("Geriatric Assessment")		819
S8	geriatric near/2 assessment*	anywhere	1792
S9	SU.EXACT ("Quality of life")		30593
S10	quality near/2 life	anywhere	57632
S11	SU.EXACT ("Risk Factors")		56654
S12	6 or 7 or 8 or 9 or 10 or 11 SU.EXACT.EXPLODE ("Self		117295
S13	concept")		62504

S14	confiden*	anywhere	64193
S15	SU.EXACT ("Trust (Social Behavior)")		7261
S16	SU.EXACT.EXPLODE ("Body Image")		10469
S17	SU.EXACT ("Emotional Intelligence")		3974
S18	SU.EXACT ("Adjustment")		15781
S19	SU.EXACT ("Emotional Adjustment")		14943
S20	SU.EXACT ("Interpersonal Relationships")		14135
S21	SU.EXACT ("Self Psychology")		2448
S22	SU.EXACT ("Behavior")		24941
S23	SU.EXACT ("Health Behavior")		19387
S24	SU.EXACT ("Motivation")		43008
S25	SU.EXACT ("Social Behavior")		17138
S26	SU.EXACT ("Social Desirability")		2631
S27	SU.EXACT.EXPLODE ("Social Isolation")		6397
S28	13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27		287392
S29	5 and 12 and 28		9341
S30	SU.EXACT ("Health Education")		10781
S31	SU.EXACT ("Social Support")		29512
S32	30 or 31		40162
S33	28 and 32		315
S34	32 NOT "Confidence interval"		278

Database: SocIndex

Date of search: 09/09/15

Platform: Ebsco via University of Plymouth

DE = Subject term

TX = text word

S1	TX elder*	all text	34944
S2	TX old*		103987
S3	DE "older people"		14032
S4	TX aged		41121
S5	DE "aging" or DE "active aging" or DE "successful aging"		10564
S6	S1 or S2 or S3 or S4 or S5		135592
S7	TX frail*		1967
S8	DE "health status indicators"		2637
S9	TX (geriatric or gerontol*) N2 assessment*		481
S10	TX quality N2 life		17715
S11	DE "quality of life"		9748

S12	S6 or S7 or S8 or S9 or S10 or S11	22229
S13	TX confiden*	26554
S14	DE "confidence"	787
	DE "Self-confidence" or DE "self-esteem"	
S15		5606
	DE "self-perception" or DE "looking glass self (psychology)" or DE "self-congruence" or DE "self-discrepancy"	
S16		8020
S17	TX "self concept"	7159
S18	DE "trust"	2804
S19	DE "body image"	1551
S20	TX emotional N2 intelligence	606
	DE "adaptability (psychology)" or DE "adjustment (psychology)"	
S21		8044
S22	DE "interpersonal relations"	31344
S23	DE "self psychology"	239
S24	DE "behavior"	12426
S25	DE "health behavior"	4140
S26	DE "social desirability"	1031
	TX social N2 behavior or TX social N2 behaviour	
S27		15622
	DE "social isolation" or DE "disengagement (psychology)" or DE "loneliness" or DE "social marginality"	
S28		5359
	DE "geropsychology" or DE "optimism in older people" or DE "positivity effect (psychology)"	
S29		459
	S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29	
S30		112478
S31	S6 and S12 and S30	1230
S32	DE "age distribution(demography)"	2021
S33	DE "health education"	3957
	DE "older people & the environment" or DE "older people - economic conditions" or DE "older people - hospital care" or DE "older people - social conditions" or DE "older people social networks"	
S34		965
	DE "services for the aged" or DE "social health maintenance organizations"	
S35		1009
	DE "senior housing" or DE "congregate housing" or DE "nursing care facilities" or DE "retirement communities"	
S36		2684

S37	DE "social support"	8301
	S32 or S33 or S34 or S35 or S36 or	
S38	S37	18510
S39	S31 and S38	216
S40	TX "confidence interval**"	9152
S41	S39 not S40	121
S42	Limit by publication date 1994-2015	111
S43	Narrow by English language	108

Database: OpenGrey

Date of search: 17-18/9/15

Platform: www.opengrey.eu

Frail elder* [no limits]	50	31 selected
older AND people AND frail*	30	14 selected
elder* AND people AND frail*	24	0 selected
(ageing OR aging) AND frail*	17	1 selected
(ageing OR aging) AND confiden*	21	2 selected
(ageing OR aging) AND wellbeing	5	0 selected
elder* AND people AND wellbeing	0	
elder* AND people AND confiden*	6	0 selected
older AND people AND confiden*	14	0 selected
older AND people AND wellbeing	6	1 selected

Appendix II: Appraisal instruments

QARI Appraisal instrument

JBQI QARI Critical Appraisal Checklist for Interpretive & Critical Research

Reviewer Date

Author Year Record Number

	Yes	No	Unclear	Not Applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is there congruity between the research methodology and the research question or objectives?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is there congruity between the research methodology and the methods used to collect data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is there congruity between the research methodology and the representation and analysis of data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is there congruity between the research methodology and the interpretation of results?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is there a statement locating the researcher culturally or theoretically?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is the influence of the researcher on the research, and vice-versa, addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Are participants, and their voices, adequately represented?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall appraisal: ☐ Include ☐ Exclude ☐ Seek further info. ☐

Comments (Including reason for exclusion)

Appendix III: QARI data extraction instrument

JBI QARI Data Extraction Form for Interpretive & Critical Research

Reviewer Date

Author Year

Journal Record Number

Study Description

Methodology

Method

Phenomena of interest

Setting

Geographical

Cultural

Participants

Data analysis

Authors Conclusions

Comments

Complete

Yes ☐

No ☐

Findings	Illustration from Publication (page number)	Evidence		
		Unequivocal	Credible	Unsupported

Extraction of findings complete

Yes ☐

No ☐

Appendix IV: Studies selected for retrieval

Abad-Corpa E, Gonzalez-Gil T, Martínez-Hernández A, Barderas-Manchado M, De IC, Monistrol-Ruano O, et al. Caring to achieve the maximum independence possible: a synthesis of qualitative evidence on older adults adaptation to dependency, *Journal of Clinical Nursing*. 2012; 21(21): 3153-69.

Barnes M, Bennett G. Frail bodies, courageous voices: older people influencing community care, *Health & Social Care in the Community*. 1998; 6(2): 102-12.

Beesley K, White JH, Alston MK, Sweetapple AL, Pollack M. Art after stroke: the qualitative experience of community dwelling stroke survivors in a group art programme, *Disability and rehabilitation*. 2011; 33(23-24): 2346-55.

Behm L, Ivanoff SD, Zidén L. Preventive home visits and health - experiences among very old people, *BMC Public Health*. 2013; 13(378): 10.

Brannstrom M, Ekman I, Norberg A, Boman K, Strandberg G. Living with severe chronic heart failure in palliative advanced home care, *European journal of cardiovascular nursing: journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*. 2006; 5(4): 295-302.

Casey D, Murphy K, Cooney A, O'Shea E. Patient perceptions having suffered a stroke in Galway, *British Journal of Community Nursing*. 2008; 13(8): 384-90.

Chang S. Beliefs about self-care among nursing home staff and residents in Taiwan, *Geriatric Nursing*. 2009; 30(2): 90.

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Resnick B. Geriatric rehabilitation: the influence of efficacy beliefs and motivation, *Rehabilitation Nursing*. 2002; 27(4): 152-61.

Sandberg M, Jakobsson U, Midlov P, Kristensson J. Case management for frail older people - a qualitative study of receivers' and providers' experiences of a complex intervention, *BMC Health Services Research*. 2014; 14.

Tung Y-C, Cooke M, Moyle W. Sources older people draw on to nurture, strengthen and improve self-efficacy in managing home rehabilitation following orthopaedic surgery, *Journal of Clinical Nursing*. 2013; 22(9/10): 1217-26.

Walker R, Johns J, Halliday D. How older people cope with frailty within the context of transition care in Australia: implications for improving service delivery, *Health and Social Care in the Community* (Print edition). 2015; 23(2): 216.

Wallin M, Talvitie U, Cattan M, Karppi S. The meaning older people give to their rehabilitation experience, *Ageing & Society*. 2007; 27: 147-64.

Appendix V: Excluded studies

Abad-Corpa E, Gonzalez-Gil T, Martínez-Hernández A, Barderas-Manchado M, De IC, Monistrol-Ruano O, et al. Caring to achieve the maximum independence possible: a synthesis of qualitative evidence on older adults adaptation to dependency.

Reason for exclusion: Did not meet PICo criteria – no descriptive meaning of confidence from the older person's perspective indicated in this systematic synthesis exploring older adult's adaption to dependency.

Barnes M, Bennett G. Frail bodies, courageous voices: older people influencing community care, Health & Social Care in the Community.

Reason for exclusion: Did not meet PICo criteria – no descriptive meaning of confidence from the older person's perspective

Behm L, Ivanoff SD, Zidén L. Preventive home visits and health - experiences among very old people.

Reason for exclusion: Did not meet PICo criteria – no descriptive meaning of confidence from the older person's perspective. Authors perspective given, linked to self-efficacy.

Brannstrom M, Ekman I, Norberg A, Boman K, Strandberg G. Living with severe chronic heart failure in palliative advanced home care.

Reason for exclusion: Did not meet PICo criteria – no descriptive meaning of confidence from narrative interviews with four older people living with severe chronic heart failure.

Casey D, Murphy K, Cooney A, O'Shea E. Patient perceptions having suffered a stroke in Galway.

Reason for exclusion: Did not meet PICo criteria – no descriptive meaning of confidence from the older person's perspective. Authors perspective links loss of confidence to a negative effect on quality of life for stroke survivors.

Chang S. Beliefs about self-care among nursing home staff and residents in Taiwan, Geriatric Nursing.

Reason for exclusion: Did not meet PICo criteria – no descriptive meaning of confidence from the older person's perspective. The author connects the narrative of care home staff to increased self-confidence through promoting self-care activities.

Ekwall A, Hallberg IR, Kristensson J. Compensating, controlling, resigning and accepting-older person's perception of physical decline.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective.

Elias T, Lowton K. Do those over 80 years of age seek more or less medical help? A qualitative study of health and illness beliefs and behavior of the oldest old.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective in this study exploring health and illness beliefs and behaviours.

Eloranta S, Routasalo P, Arve S. Personal resources supporting living at home as described by older home care clients.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective.

Greysen SR, Hoi-Cheung D, Garcia V, Kessell E, Sarkar U, Goldman L, et al. 'Missing Pieces' - Functional, Social, and Environmental Barriers to Recovery for Vulnerable Older Adults Transitioning from Hospital to Home.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective in their transitions from hospital to home.

Kristensson J, Hallberg IR, Ekwall AK. Frail older adult's experiences of receiving health care and social services.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective.

Lee VS, Simpson J, Froggatt K. A narrative exploration of older people's transitions into residential care.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective despite mention of participant's discussion of not feeling confident in the abstract

Nicholson C, Mayer J, Flatley M, Holdman C. The experience of living at home with frailty in old age: A psychosocial qualitative study.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of

confidence from the older person's perspective. 'Loss of Confidence' referred to within people's narrative accounts of living with frailty.

Nicholson C, Meyer J, Flatley M, Holman C, Lowton K. Living on the margin: Understanding the experience of living and dying with frailty in old age.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective despite the author highlighting the recurrent phase 'loss of confidence' in narratives of 17 participants.

Sandberg M, Jakobsson U, Midlov P, Kristensson J. Case management for frail older people - a qualitative study of receivers' and providers' experiences of a complex intervention.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective.

Walker R, Johns J, Halliday D. How older people cope with frailty within the context of transition care in Australia: implications for improving service delivery.

Reason for exclusion: Did not meet PICO criteria – no descriptive meaning of confidence from the older person's perspective despite many contextual references to trust and mutual confidence in the case management arrangements between professional and the person.

Appendix VI: List of study findings

Beesley K, White JH, Alston MK, Sweetapple AL, Pollack M. Art after stroke: The qualitative experience of community dwelling stroke survivors in a group art programme. Disabil Rehabil. 2011; 33(23-24): 2346-55.	
Finding 1 [Unequivocal]	Experience of stroke
Illustration	<p>“Accompanying feelings of isolation, participants experienced reduced confidence and altered mood following stroke ... Participants explained having difficulty with adjusting to life after stroke meant they were less confident to try new experiences or to engage in the community.” (p.2350)</p> <p>“I haven't got the confidence I used to have before I had the stroke ... It's [confidence to do things] a big challenge now. It never used to be but now it is. (Participant 3, female, age 72)” (p.2350)</p> <p>“[After a stroke] your confidence had been knocked around a fair bit ... there's a lot of things you can't achieve. (Participant 1, male, aged 53, FG)” (p.2350)</p>
Finding 2 [Unequivocal]	Benefit of art
Illustration	<p>“Creative outlet ... self-awareness ... increased confidence ...lifestyle benefits. Another key factor contributing to increased confidence was the opportunity for participants to interact socially with other group members. Socialising with other group members increased confidence and self-esteem.” (p.2350-2351)</p> <p>”I would encourage someone to do it ...[stroke] knocks your confidence for six, even if its minor ... suddenly you find you can't do things. But if you can come [to the group], with an open mind and allow what happens, the confidence grows in you, it's positive. (Participant 5, female, age 65, FG)” (p.2351)</p>
Finding 3 [Credible]	Benefits of a group setting

Illustration	<p>“Some participants indicated they were 'not arty' (Participant 2) or 'not very artistic' (Participant 5). Despite this, they reportedly 'enjoyed the group' (Participant 2) which helped them 'smile a lot more' (participant 5) by being with other stroke survivors. Enjoyment was still able to be identified when feeling challenged by the art process...” (p.3352)</p>
Resnick B. Geriatric rehabilitation: The influence of efficacy beliefs and motivation. Rehabil Nurs. 2002; 27(4): 152-61.	
Finding 1 [Unequivocal]	Personal expectations
Illustration	<p>“Personal expectations were described as three types of belief - specific beliefs about ability (self-efficacy), specific beliefs about outcomes (outcome-expectations) and general beliefs about outcomes (general outcome expectations) ... Specific outcome expectations were described as a belief that performing a certain activity would result in an expected outcome (i.e. participation in rehabilitation will improve functional performance). This belief motivated individuals to participate in the rehabilitation programme.” (p.154)</p> <p>“I am confident the therapy is going to help. If I wasn't confident, I would not go to therapy, I would leave!” (p.154)</p>
Finding 2 [Credible]	Information influenced efficacy beliefs
Illustration	<p>“Participants indicated that their beliefs about their ability to perform specific activities and to participate in rehabilitation aimed at their overall recovery were, to varying degrees, influenced by role models, verbal encouragement, their own progress in rehabilitation, past experiences, spirituality and physical sensations.” (p.155)</p> <p>“what they are doing here is teaching me a lot that I didn't know and letting me practice. What it is doing for me is helping me, not you people, but helping me a whole lot. After I practice and progress here I believe that I can go home and do the same things.” (p.155)</p>
Tung Y-C, Cooke M, Moyle W. Sources older people draw on to nurture, strengthen and improve self-efficacy in managing home rehabilitation following orthopaedic surgery. J Clin Nurs. 2013; 22(9/10): 1217-26.	
Finding 1 [Unequivocal]	Nurturing self-efficacy through working with others

Illustration	<p>“all participants accepted nurturing support from their social network [Family and friends] or sought assistance from community services to gain more confidence in dealing with their situation.” (p.1220)</p> <p>“I had my daughter come and do the work for the first week, look after me, stay with me ... she did everything. She was a great help. ... you know that was what I needed to have someone here with me for the first week and then I said you can go home because I was more confident and you didn't need to be here. (Jessica)” (p.1220)</p>
Finding 2 [Credible]	Strengthening self-efficacy through accessing personal values and beliefs
Illustration	<p>“This theme presents the way participants accessed their personal values and belief following orthopaedic surgery as a source to strengthen their self-efficacy and become confident in continuing rehabilitation ... belief in the importance of exercise ...positive attitude.” (p.1220-1221)</p> <p>“So what I've got to do now is to force myself into doing a little bit of exercise every day ... going for a walk to the end of the road and back... (Ron)” (p.1221)</p>
Finding 3 [Unequivocal]	Improving self-efficacy through adaptive strategies and goal setting
Illustration	<p>“Participants were able to improve their self-efficacy in relation to the rehabilitation programme at home through adaptations and modifications made to daily activities and by setting goals to continue their normal lives and activities. These consequently increased their overall confidence in managing challenging situations within the rehabilitation process... Participants used various walking aids and facilities, depending on individual capability, to improve confidence with situations and environments. They thought this allowed them to continue with their independent living...” (p.1222)</p> <p>“Well, when I first came home and i had a walker, you know and I walked around here and I hated it, but it gave me great confidence, It really did give me confidence...(Diana)” (p,1222)</p>
Wallin M, Talvitie U, Cattan M, Karppi S. The meaning older people give to their rehabilitation experience. Ageing & Society. 2007; 27: 147-64.	
Finding 1 [Unequivocal]	A sense of confidence with everyday life

Illustration	<p>“This category 'sense of confidence with everyday life' includes ... the various benefits they perceived from the rehabilitation. Many of these were framed in a coherent story that described incidents in their lives that were challenging or had caused problems. ...benefits were interwoven with senses of being able to take care of oneself, of coping with everyday life, with improving physical ability and with experiencing encouraging interactions with the staff.” (p.152)</p> <p>“Q: If you consider the meaning of this spell in rehabilitation in terms of how you can manage at home, what in your opinion have been the benefits? A: Well it's been pretty good, it's given me a lot of confidence. You began to feel you can cope on your own ... without help. like these nurses no longer have to come round twice a day, not even once. So it's given (me) the confidence to cope without help at home.” (p.154)</p> <p>“Q: Whose idea was this that you practice these kinds of things? A: Well it was getting out of a chair, this was what they were teaching us. We used a higher chair to get up and then next a lower one ... and then I said that I'll fall over and I won't be able to get up. And then we started talking, and they asked me, 'Should we practice this?' and I said 'absolutely'. And then we tried it, several times, and every day it went better and better. It really helped build up your confidence (to the point that I) can get up.” (p.154)</p>
Finding 2 [Credible]	Sense of vacation
Illustration	<p>“This sense of vacation was manifest in the expression of carefree living, enjoyment and pleasant social interaction.” (p.154)</p> <p>”Yes it really is wonderful that a person like myself ... I mean, I spend a lot of time at home, I don't really go out very often ... I suppose, you could say, because I no longer have the energy or ability. I mean, you know, my age; so yes, this really is wonderful. I would certainly recommend this kind of holiday; I'd be delighted to come again.” (p.154-155)</p>
Finding 3 [Credible]	Sense of disappointment in the rehabilitation program
Illustration	<p>“The participants who tended to be among the more articulate and more proactive when at home in reaching their goals went to the rehabilitation programme, which appeared to them to</p>

	<p>have a pre-set format and to lack opportunities for participation in its planning or goal setting.”; (p.156)</p> <p>“Q: Did I get this right? You felt you didn't have enough say about what went on there? A: Well, no I didn't, I mean the programme was all set out in advance when we went there, we always had to go, whenever (laughs), when it was time to go, so there really wasn't very much negotiation or questions as to who wanted what.” (p.156)</p>
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Appendix 2: Appendices from Chapter 4

Appendix 1 – Supplementary Information

The Concept of Confidence

Defining Attributes: Confidence in Frail Older People

Recorded alphabetically

Key:

- ☐ Primary reference from literature search (n. 21)
- ☐ Secondary reference (n. 13)

Reference and study context	Text Quote	Attribute / Interpretation
<p>Barnes and Bennett (1998)</p> <p>A study evaluating a project designed to empower older peoples' contribution to health and social care developments in their local community.</p>	<p>The project was based on a belief in the value of meeting together as a means through which people could develop the confidence to express their views. (Abstract p.102)</p> <p>Empowerment comprises a growing confidence and ability within the individual, as well as an increase in the objective circumstances enabling the individual to exert influence (Barnes & Walker 1996). (p.110)</p>	<ul style="list-style-type: none"> • Meeting together could develop confidence to express views. • A component of empowerment. • Growing confidence linked to words: ability and meeting together. • Confidence link words: Empowerment,
<p>Beesley et al. (2011)</p> <p>A study that aimed to qualitatively explore the experience of community dwelling stroke survivors' participation in an arts health group programme and possible health benefits to quality of life</p>	<p>Participants experienced improved confidence, self-efficacy, QOL and community participation through involvement in an arts health programme. (Abstract p,2346)</p> <p>Participation in activities following stroke may be further influenced by reduced confidence and reduced self-efficacy [14-16]. (p. 2346)</p> <p>Arts health includes the use of interventions such as music, performing arts, literature, and visual arts, to address aspects of wellbeing such as confidence and participation. (p. 2347)</p>	<ul style="list-style-type: none"> • Improved confidence through involvement / participation in arts health programme. • Reduced confidence and mood associate with isolation and linked to residual symptoms of stroke. • Achievement linked to

<p>(QOL) and wellbeing.</p>	<p>Accompanying feelings of isolation, participants experienced reduced confidence and altered mood following stroke, linked to the experience of ongoing residual symptoms. Participants explained having difficulty with adjusting to life after stroke meant they were less confident to try new experiences or to engage in their community.</p> <p>'I haven't got the confidence I used to have before I had the stroke ... It's [confidence to do things] a big challenge now. It never used to be but now it is'. (Participant 3, female, age 72)</p> <p>'[After a stroke] your confidence had been knocked around a fair bit ... there's a lot of things you can't achieve'. (Participant 1, male, age 53, FG) (p. 2350)</p> <p>Increased confidence. A major benefit of the art group was that participants gained an increased sense of confidence. Most participants had limited art experience and were surprised at the quality of their artworks, which gave them a sense of accomplishment and 'courage to keep going' (Participant 8). (p. 2351)</p> <p>Participants reported a sense of achievement which contributed to increased confidence. (p. 2351)</p> <p>'I would encourage someone to do it ... [stroke] knocks your confidence for six, even if it's minor... suddenly you find you can't do things. But if you can come [to the group], with an open mind and allow what happens, the confidence grows in you, it's positive'. (Participant 5, female, age 65, FG) (p. 2351)</p> <p>Another key factor contributing to increased confidence was the opportunity for participants to interact socially with the other group members. For participants who had limited social interaction, the art group provided a means 'to get out and talk to other people' (Participant 9). Socialising with the group members increased confidence and self-esteem. (p. 2351)</p>	<p>confidence improvement.</p> <ul style="list-style-type: none"> • Social interaction the activities offered was linked to increased confidence. • Personal and rehabilitation benefits experienced from attending an art group and included increased confidence, self-awareness and social interaction. • Confidence link words: Self-efficacy, QOL, Community participation, Altered mood, Well-being, Isolation, Courage, Achievement
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	<p>The group provided an opportunity for social interaction post-stroke, and participants reported experiencing enjoyment, increased confidence and self-esteem. (p. 2353)</p> <p>While there is limited research into arts interventions after stroke our results echo with findings regarding arts interventions in other chronic disease groups and the benefits of art in distracting thoughts away from the illness experience, improving self-confidence, well-being and social contacts [32,33]. (p. 2353)</p> <p>An important finding of this study was the personal and rehabilitation benefits experienced from attending an art group and included increased confidence, self-awareness and social interaction. These gains contributed to improved self-efficacy in the participants through undertaking a new task. (p. 2353)</p> <p>Research has demonstrated that stroke survivors with a positive self-efficacy report higher QOL and fewer depressive symptoms [15]. This study suggests that self-efficacy, confidence, QOL and participation are enhanced by an arts health programme. (p. 2353)</p>	
<p>Bensadon (2011)</p> <p>Thesis: This thesis examined aging stereotypes, Memory Self-Efficacy (MSE) and memory performance in older and younger adults.</p>	<p>This effect was stronger for older adults. Cumulatively, these results illustrate that memory has increasing personal relevance as people age, and underscore the key roles of memory-specific anxiety and self-confidence (e.g., MSE) in predicting memory performance. (p.10)</p> <p>Self-efficacy is one's sense of competence and confidence for a given task in a given domain. (p.29)</p> <p>Bandura (1997) has highlighted the persuasive influence such messages can exert on one's domain-specific confidence (i.e., self-efficacy), and ultimately, performance. (p.72)</p> <p>Therefore, it is likely that older adults' pre-existing beliefs in stereotypes, fading</p>	<ul style="list-style-type: none"> • Memory has an increasing personal relevance as people age and is associated with self-confidence. • Competency and confidence are components of self-efficacy. • Confidence affects performance. • Pre-existing beliefs in stereotypes, confidence, and performance

	<p>confidence, and actual performance differences all influence each other over time. (p.73)</p> <p>As mentioned, the most parsimonious model included older adults only and showed MSE significantly predicting performance, accounting for nearly 10% of the variance in memory recall scores. Considering that MSE is largely a measure of one's confidence and belief in self, this is not an insignificant number. (p.82)</p>	<p>influence each other.</p> <ul style="list-style-type: none"> • Self-belief and confidence are related to Memory Self-Efficacy. • Confidence link words: Self-confidence; Competence; Self-efficacy; Performance; Belief; Stereotypes; Self-belief; Memory Self-Efficacy.
<p>Chandler et al. (1998)</p> <p>Study to determine whether strength gain is associated with improvement in physical performance and disability.</p>	<p>Strength gain is also associated with improvement in confidence in mobility. (Abstract p.24)</p>	<ul style="list-style-type: none"> • Strength gain improved mobility confidence. • Confidence link words: Mobility, Strength gain.
<p>Claassens et al. (2014)</p> <p>The study aims to investigate the concept of health care-related perceived control from the viewpoint of frail older adults.</p>	<p>Perceived control reflects the feeling or belief that health care is under control, which is constituted by five, either internal or external, factors: (I) self-confidence in organising professional and/or informal care, (II) self-confidence in health management in the home setting, (III) perceived support from people in the social network, (IV) perceived support from health care professionals and organisations, and (V) perceived support from (health care) infrastructure and services. (p.159)</p> <p>Our findings indicated that the level of perceived control was dependent on the factors that constitute it: when all factors were favourable (sufficient support possibilities as well as confidence in own abilities), perceived control was high. (p.167)</p>	<ul style="list-style-type: none"> • Self-confidence is a factor of perceived control. • Confidence in own abilities increases level of perceived control. • Ability to handle own healthcare situation at home (professionals and informal care) • Having a supporting social network, sharing tasks with significant others, or handing over

	<p>In particular, some benefitted from an adequate supporting social network, sharing tasks with significant others, or handing over actual control to compensate for loss of (confidence in) their own functioning. (p.167)</p> <p>In contrast, some other respondents clearly had a strong confidence in being able to handle their own health care situation. Especially those who lived alone without a supporting network and who were used to fall back on their own skills throughout their lives, strongly emphasised their abilities. (p.167)</p> <p>Perceived control in health care among frail older people is a subtle and complex concept. It is constituted by the experience that health care is under control and not only based on people's perceptions of their personal control, i.e. their self-confidence on the domains of organising care and managing their health in their home situation. (p.168)</p>	<p>actual control to others compensated for loss of confidence in own function.</p> <ul style="list-style-type: none"> • Those with strong confidence lived alone without a supporting network and were used to falling back on their own skills throughout their lives. • Self-confidence relates to personal control (internal perceived control, as opposed to external perceived control). • Confidence linked words: Self-confidence, Control, Function, Ability, Health management, Social network, Support.
<p>Donnelly and MacEntee (2012)</p> <p>A paper drawing on theories of ageing, body image and disfigurement, to explore the potential for relationships between oral health, body image and social interactions between</p>	<p>A positive body image increases confidence in social interactions, which contributes substantially to health, well-being and quality of life. (Abstract p.e28)</p> <p>But we have very little empirical information about how it is influenced by impairments and diseases of the mouth. Halitosis, tooth loss, and poor dental aesthetics undoubtedly disturb social interactions between people who live and work independently in society, and resolution of these dental problems can improve social confidence. (p.e28)</p> <p>Essentially, a positive body image provides confidence to engage in social</p>	<ul style="list-style-type: none"> • Positive body image increases confidence in social interactions. • Confidence in social interactions leads to substantial health, well-being and quality of life. • Oral health problems have a negative effect on social

institutionalised older people.	<p>relations, whilst a negative image decreases the ability and desire to socialise (p.e30)</p> <p>Halitosis is not physically disfiguring but can disturb body image and self-confidence. (p.e30)</p>	<p>interaction for which resolution can improve social confidence.</p> <ul style="list-style-type: none"> • Positive body image provides confidence in social relations. • Confidence linked words: Body Image, Social interaction, Social confidence.
<p>Doughty et al. (2000)</p> <p>A study designed to develop and evaluate a wearable falls detector.</p>	<p>Their [falls] early detection is an important step in providing people with the reassurance and confidence necessary to maintain an active lifestyle. (Abstract p.S1:150)</p> <p>Identification of those who are at risk [of falls] and action to reduce those risks must begin with the reliable detection of falls. Only then will individuals have the confidence to regain their mobility and their independence which will, in turn, reduce the likelihood of future falls. (p.S1:151)</p>	<ul style="list-style-type: none"> • Confidence is necessary to maintain an active lifestyle. • Falls risk identification and action will give individuals confidence to regain their mobility and independence. • Individuals with the confidence to regain their mobility and independence will reduce the change of future falls. • Confidence link words: Reassurance, Lifestyle, Mobility, Independence, Falls.
<p>Foltyn (2015)</p> <p>Article reporting a series of case studies to illustrate the need for action for older people's oral healthcare</p>	<p>Mouth pain can be devastating for the elderly, compound psychosocial problems, frustrated carers and nursing home staff and disruptive family dynamics. As appearance function and comfort suffer, so may a person's self-esteem and confidence. (Abstract p.86)</p>	<ul style="list-style-type: none"> • Oral/dental appearance, function and comfort may affect a person's confidence. • Confidence link words: Self-

within care home settings.		esteem; Oral health.
Henderson et al. (1998) Book chapter: The role of exercise and falls risk reduction in the prevention of osteoporosis.	In the frail elderly, activity to improve balance and confidence also may be valuable. (Summary p.380)	<ul style="list-style-type: none"> • Activity improves balance and confidence in the frail elderly. • Confidence link words: Balance, Activity.
Heyneman and Premo (1992) Evaluation proposal of a low-cost aquatic exercise programme compared to an aerobic programme.	In addition to the psychological benefits of exercise there is mounting evidence that there are significant psychological advantages as well. Subjects participating in regular aerobic training have reported feelings of increased well-being and decreased incidence of stress and depression (9,19). Studies on older aerobics participants consistently describe significant improvements in self- confidence , social life, sleep patterns, and sex life associated with moderate regular activity (14,20,21). Improvements in the cognitive functioning of older adults from exercise also have been shown (22,23) (p. 214)	<ul style="list-style-type: none"> • Confidence boosted by exercise programmes. • Confidence link words: Self-confidence, Activity.
Jancewicz (2001) A literature review exploring evidence as to the potential for Tai Chi in the prevention and treatment of many conditions associated with ageing, amongst them loss of balance and strength (frailty), and cardiorespiratory function, as well as psychological factors associated with the ageing process.	This literature review focuses on the increasing evidence of Tai Chi as an exercise activity which can improve fitness, and that with regular application can lead to an increase in functional abilities of coordination and joint mobility, as well as improve self-esteem and confidence . (Abstract p.70)	<ul style="list-style-type: none"> • Tai Chi can improve self-esteem and confidence. • Confidence linked words: Self-esteem; Increased functional ability (coordination and joint mobility); Tai Chi.

<p>Kelly et al. (2016)</p> <p>Study of how age and aging is represented in popular music lyrics.</p>	<p>It is imagined that the negative representations of age and ageing can be dispiriting, confidence and esteem lowering for older people and their potential impact might be considered carefully by artists. (Abstract p.1325)</p> <p>It is imagined that the negative representations of age and ageing can be dispiriting and confidence and esteem lowering for older people and that more scrutiny of these texts by censorship boards should be exercised. (p. 1332)</p>	<ul style="list-style-type: none"> • Negative representation of age in music texts possibly lowers confidence in older people. • Confidence link words: Dispirited, Low esteem.
<p>Kutner et al. (1997)</p> <p>A study reporting older peoples self-reported benefits of Tai Chi and Balance Training</p> <p>Sense of confidence measured (not balance confidence)</p>	<p>Specific benefits of the [Tai Chi] TC exercise training that were mentioned included better coordination and balance, increased alertness, confidence, relaxation, better mental outlook, and a sense of achievement. (p.245)</p> <p>Two major factors contributed to TC and [Balance Training] BT subjects' change in confidence, based on the exit interview responses: (1) a perception of having gained a better sense of balance and feeling more secure in their ambulation, and (2) an enhanced generalized sense of well-being. Improved balance was the confidence-boosting factor that was most emphasized by BT subjects (75%); for example, subjects reported feeling "more sure-footed, especially going up hills," or "more conscious of various aspects of balance, especially the role of feet and ankles." The remainder of the BT group (25%) cited an enhanced sense of well-being, e.g., "assisted me in feeling better about myself and sharpening my positive thinking."</p> <p>TC subjects, however, were almost equally likely to attribute their improved sense of confidence to improved balance (54%) and to an enhanced sense of well-being (46%). Some TC subjects said they felt "less likely to lose balance if disturbed" and felt "more secure in movement".</p> <p>TC subjects who referred to enhanced well-being as the reason for their changed sense of confidence made comments such as "just generally felt better," "gained a general overall feeling of well-being,"</p>	<ul style="list-style-type: none"> • Confidence improved through gaining a better sense of balance and feeling more secure in walking*. • Confidence improved through a generalised sense of well-being*. • Improved balance was a confidence-boosting factor. • Older people need to feel confident to continue to be mobile. • Feeling of confidence linked to psychological well-being. • Confidence link words: Coordination, Balance, Alertness, Relaxation, Mental outlook, Security Achievement, Confidence-boosting,

	<p>and "TC has encouraged me". These perceptions of improved balance and well-being may have contributed to TC participants' significant improvement in fear of falling (Wolf et al., 1996). (p.245)</p> <p>Older persons need to feel confident to test the limits of their environment and to continue being mobile, which both the TC and the BT interventions seemed to promote. However, experiencing more generalized feelings of confidence and of overall psychological well-being, in the context of an enjoyable activity, may effectively motivate older persons to make exercise an ongoing part of their lives. (p.245-6)</p>	<p>Psychological well-being, Fear of falling, Motivation.</p> <p>*both linked to a reduced fear of falling</p>
<p>Lelard and Ahmaidi (2015)</p> <p>A review the effects of physical activity on balance performance in the elderly.</p>	<p>Training programs offering a combination of several activities have demonstrated beneficial effects on the incidence of falls, and we present and compare the effects of these two types of training activities. It emerges that there are differential effects of programs of activities: while all activities improve participants' confidence in their ability, the "proprioceptive" activities rather improve performance in static tasks, while "strength" activities tend to improve performance in dynamic tasks. (Abstract p.357)</p> <p>Fear of falling and its correlates in balance confidence can also reflect poorer functional mobility and reduced independence in older adults. (p.358)</p> <p>It was demonstrated that if balance confidence has decreased with retirement, it could be improved with exercise program. (p.358)</p> <p>In terms of balance confidence, improvement was shown to be associated with changes in physical ability. (p360)</p> <p>In the frailest older individuals, fear of falling is a pre-dominant characteristic, which seems to be the main factor in determining loss of autonomy. Thus, in this population, with the objective to restore confidence in their capacity to maintain balance, any type of training</p>	<ul style="list-style-type: none"> • Post-fall training programme activities improve participants' confidence in their abilities. • Fear of falling affects balance confidence. • Poor balance confidence reflects poor functional mobility and reduced independence. • Confidence can be improved with exercise programmes. • Improvement in balance confidence is associated with positive physical ability. • Restoring confidence with the frailest old is effective through balance maintaining exercise programmes.

	<p>program could be proposed (balance, gymnastics, strength-training programs or educational program). (p.365)</p>	<ul style="list-style-type: none"> • Confidence link words: Physical ability, Fear of falling, Mobility, Independence, Loss of autonomy, Balance confidence, Exercise programme.
<p>Li (2005)</p> <p>The study examines the effects of psychosocial and health factors on the activities of daily living disability trajectory of low-income frail older people living in the community.</p>	<p>The analysis shows that major risk factors for a poor activity of daily living (ADL) disability trajectory include being Black, older, living with non-spouse others, and no confidence in functional improvement. (Abstract p. 615)</p> <p>Self-efficacy, referring to one's confidence in successfully performing intended behaviors (Bandura 1986), has been found to slow down functional decline among older persons with low functioning (Kempen et al. 1999) or experiencing decreasing physical performance (Mendes de Leon et al. 1996). (p. 617)</p> <p>The major risk factors for a poor ADL disability trajectory found in this study include being Black, older, living with non-spouse others, and no confidence in functional improvement. (p. 634)</p> <p>Some chronic conditions including cancer, dementia, and Parkinson's disease, as well as limitations in vision, bladder, and bowel, are significantly correlated with capability of functional improvement, suggesting that confidence in improvement may have objective health basis. (p. 635)</p> <p>Given the positive effects of capability of functional improvement on frail elders' ADL disability trajectories, future research that investigates what affects the confidence in functional improvement may help to design strategies to increase such confidence and consequently improve functional ability of frail elderly persons in the community. (p. 635)</p>	<ul style="list-style-type: none"> • Having no confidence in functional improvement is linked to the threat of ADL decline over time. • Confidence is linked to slowing down functional decline in disabled older people. • Confidence in improvement may have an objective health basis. • Confidence link words: Functional decline, Self-efficacy, Health benefit.

<p>McDougall and Balyer (1998)</p> <p>An article examining the effects of aging on memory and the intertwining factors of depression and self-efficacy as treatable antecedents of mental frailty in older adults.</p>	<p>Compromised thinking, anxiety, and decreased confidence in memory are symptoms of mental frailty. (Abstract p.220)</p> <p>Overall, participants whose depression scores were higher, as measured by the Geriatric Depression Scale, had significantly lower memory confidence or self-efficacy scores than did subjects with lower depression scores. Two weeks after the memory improvement course, both depressed and non-depressed participants showed significant improvement in memory confidence and self-efficacy. (p.221)</p> <p>The concept of self-efficacy may be defined as our confidence in our ability to perform effectively in a given situation. (p.221)</p> <p>As we lose confidence in memory, our anxiety increases, and our sense of self-efficacy erodes. Individuals who have less confidence may even give up trying because they doubt their ability to achieve their desired performance level. On the other hand, they may be convinced of their abilities but give up trying because of an unresponsive or punishing environment. (p.221)</p> <p>Repercussions of this lack of confidence in memory ability may include a generalized negative self-concept, the perception that others have a better memory than they, and a fear of impending senility or dementia. (p.221)</p> <p>Activities beyond their abilities will result in agitation, anxiety, withdrawal, refusal to attempt even manageable challenges, decreased confidence, and further progression of memory problems. (p.223)</p> <p>In addition to training in specific memory strategies, elderly people often need help developing confidence in their skills and memory performance ability. Such confidence can be expected to increase their feelings of self-efficacy and belief in personal control, resulting in reduced</p>	<ul style="list-style-type: none"> • Decreased confidence in memory (along with compromised thinking, anxiety) are symptoms of mental frailty. • Depression is associated with lower memory confidence. • Improving depression improves memory confidence and self-efficacy. • Self-efficacy may be defined as our confidence in our ability to perform effectively in a given situation. • Loss of memory confidence is associated with increased anxiety. • Many factors exist in which older people with less memory confidence may give up trying. Because they doubt their ability to achieve; perform at a desired level; unresponsive environment; punishing environment. • Lack of memory confidence promotes a
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	depression and anxiety and stabilized mental frailty. (p.223)	<p>negative self-concept.</p> <ul style="list-style-type: none"> • Lack of memory confidence may be associated with fear of impending senility or dementia. • Memory confidence activities that go beyond older peoples' abilities decrease confidence. • Memory confidence development can be expected to increase self-efficacy and belief in personal control. • Confidence link words: Self-efficacy, Memory, Memory Confidence, Anxiety, Mental frailty, Depression, Dementia, Ability (to perform), Self-concept, Withdrawal, Refusal to attempt, training strategies, Skill development, personal control.
<p>McNamara et al. (2016)</p> <p>A study to evaluate a healthy ageing intervention (physical and social activity) for frail older</p>	<p>Program participants reported better health, social function and mental well-being; greater engagement in household and leisure activities; and increased enjoyment and confidence through participating in the program. Some participants could not attend the whole program due to poor health or difficulties securing transport. (abstract p.30)</p>	<ul style="list-style-type: none"> • Confidence grew through participation in the programme of physical and social activity. • Confidence is a non-physical effect – linked words:

people living in the community.	<p>Although the program focused on physical activities, the participants clearly thought the benefits extended beyond feeling physically fitter. These benefits included a sense of confidence, motivation and elevated mood. (p.33)</p> <p>Improvement in physical health was demonstrated over the post-evaluation period with comments such as 'I was able to walk a bit straighter', 'felt freer in movement' and 'I had better balance'. One participant commented, 'It is the case of getting confidence to do something'. (p.33)</p> <p>They felt that the participants' confidence grew and friendships developed as the program progressed: 'I've seen all sorts of interactions and relationships created within that environment, which is a really positive thing.' (p.34)</p> <p>The qualitative results indicated that participants perceived their health to be better and their confidence to be greater. (p.34)</p> <p>Many of the participants reported that their confidence grew, they felt better physically, their mood improved and they had better concentration. The program appeared to improve general resilience and connectedness to others in the community. Many of the participants stated their satisfaction in being able to get out of their home to join in activities with other people like themselves. (p.34)</p>	<p>Motivation and mood.</p> <ul style="list-style-type: none"> • Older person uses the words 'it's a case of getting confidence to do something' relating to their physical health improvement. • Confidence grows and friendships develop. • Health and confidence were evaluated as better because of the programme. • Confidence grew as physically they improved and their mood and concentration improved. • Confidence link words: Leisure activities, Social function, Mental well-being, Engagement, Motivation, Mood, Resilience, Health, Concentration, Friendships, Relationships, Community, Connectedness, Activities.
<p>Menzies and Hanger (2011)</p> <p>The study describes the type and level of support provided by a facilitated discharge</p>	<p>Patients with the highest number of contacts were those referred with patient anxiety/low confidence (7.4), and family concern (8.4). (Abstract p.29)</p> <p>Poor mobility or falls risk and poor cognition were the most common single reasons for referral to the FD service. Patient anxiety / low confidence, and</p>	<ul style="list-style-type: none"> • The word anxiety is used as a work to mean equally low confidence [/ = or]. • Low confidence and family concerns

team to frail older patients discharging from an elderly rehabilitation hospital and the outcomes achieved.	family concern referral reasons had a trend to needing more resources than the average (14% and 29% higher respectively). However, poor mobility or falls risk had a trend to using fewer resources than the average (17% lower). (p.35)	<p>resulted in higher resource use in this facilitated discharge service.</p> <ul style="list-style-type: none"> Confidence link words: Low confidence, Anxiety, Concerns, Mobility, Falls risk, Resources.
<p>Oliver (2007)</p> <p>An article setting out the key practice points for community nurses and the key sources of evidence for practice development to initially assess, intervene and monitor older people presenting with a fall.</p>	<p>There is plenty that clinicians can do to reduce the chance of further falls and injuries, to optimize patients' confidence and ability to cope and to use falls as a 'case-finding' trigger to address a host of other, often unrecognized problems. (Abstract p.500)</p> <p>Falls may also result in a distressing 'long lie' where victims are unable to get up—and this in turn may lead to pressure damage, dehydration or hypothermia. Falls also lead to anxiety, fear of failing or loss of confidence (Scott V et al, 2007) and worry for relatives and carers—all of which can lead to progressive loss of function, constriction of life-space and increasing dependency. (p.500)</p> <p>...as well as how the falls are impacting on the person's confidence, mood and quality of life and their own attitude to risk-taking or taking professional advice on safety. (p.504-505)</p> <p>There is a real danger that an over-custodial and risk-averse approach will lead to that person feeling their autonomy has been overridden and to a further loss of confidence. (p.506)</p>	<ul style="list-style-type: none"> Confidence linked to falls. Falls can lead to anxiety, fear of falling and loss of confidence—which can lead to loss of function, constrictions in life space and increased dependency. Confidence associated with mood, quality of life risk taking behaviours and taking professional advice. Care providers being too risk adverse can lead to further confidence loss through loss of autonomy. Confidence link words: Coping; Falls; Fear of falling, Ability, Loss of function, Mood, Quality of life, Increased dependency, Autonomy.
Parry et al. (2016)	Falls cause fear, anxiety and loss of confidence , resulting in activity	<ul style="list-style-type: none"> Falls cause fear, anxiety and loss of confidence.

<p>Health Technology Appraisal. Two phase study: 1) develop a Cognitive Behaviour Therapy intervention (CBTi) delivered by health-care assistants (HCAs) and 2) through a Randomised Controlled Trial to measure the impact of the intervention, its acceptability and cost benefits of the intervention.</p>	<p>avoidance, social isolation and increasing frailty. (Abstract p.vii)</p> <p>Many older individuals, both fallers and non-fallers, suffer from a variety of adverse psychosocial difficulties related to falling including fear, anxiety, loss of confidence and impaired self-efficacy (in this context the self-perception of ability to walk safely without falling) resulting in activity avoidance, social isolation and increasing frailty. (p.xxix and p.1)</p> <p>About one-third of the interviewees conformed to the prevailing picture of fear of falling in the medical literature whereby fear, often but not always occasioned by a fall, is maintained by avoidance of activity, leading to loss of confidence, physical weakening and more fear of falling. (p.7)</p> <p>All stakeholder groups participating in qualitative interviews were asked for advice and suggestions. It was seen as essential to ensure that the title was positive: avoid the word 'falling' (as well as any words beginning with 'psych') and to consider including terms such as 'confidence', to which people would be able to relate. In addition to being non-threatening, we wanted the name to convey a sense of the purpose and focus of the intervention so that it would not be mistaken for an exercise class. Following discussions, we agreed on STRIDE as the brief study title (Strategies for increasing independence, confidence and energy).(p.15)</p> <p>"I mean I've used it a lot with working with older people and it's not actually called CBT but it's what you do with them from the point of view you've gradually got to build their confidence up through very simple increasing their activities and things and the way you talk to them and the way you encourage them and things like that as well, so yes I think it would be very, very helpful actually." P5, briefing meeting for clinic staff, 17 February 2012 (p.16)</p>	<ul style="list-style-type: none"> • Loss of confidence, resulting in activity avoidance, social isolation and increasing frailty. • Loss of confidence is a psychosocial difficulty related falling. • Fear often associated with a fall leads to loss of confidence. • Stakeholders chose the word confidence in preference to a 'psych' type work. • Confidence can be built up by simple increases in activity. • The functional reach test is a good indicator of confidence in balance and increased risk of having a fall. • Confidence comes back as physical strength comes back. • By knowing what to do when you fall you can gain confidence. • Confidence increased by being told you could do it. • Overcoming embarrassment and shame associated with
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	<p>The functional reach test is a good indicator of confidence in balance and increased risk of having a fall [78,79] (p.26)</p> <p>STRIDE therapists and clients agreed that the CBTi was most effective after any medical issues had been resolved, as it enabled clients to maximise the benefits of their improved health by tackling any residual loss of confidence and encouraging them to try new activities: “If you work on that physical strength, definitely the confidence comes back. But [. . .] the variety of applications of that confidence is quicker because you’re getting different ideas of how to apply it.” C5969 interview, 29 January 2014 ...</p> <p>... “Well I’m still worried about it [falling] because I’ve got Parkinson’s and I shake a lot but I was like given a lot of confidence when I actually did fall just by what she said ‘well just sit there and take some deep breaths and then try to get up and make sure you’re all right’ and that sort of thing. I’m still confident with that.” C4465, interview, 26 June 2014 (p.82)</p> <p>[Domain] Increased confidence: [Example] “She just told us I could do it. I just, I felt I would never be able to do anything again. And when ST2 told us to try, I went and said, ‘Maybe I can do it’” C4458 interview, ST2, 2 July 2014 “Certainly I’m very much more confident than I was before it started” C5377 interview, ST1, 30 June 2014 (p.95)</p> <p>[Domain] Increased self-acceptance [Example] “I’ve got over the feeling that it [falling] is totally embarrassing and it’s not right to fall, it’s not shame to fall flat or whatever, you know. And now I think if I fell I would be all right. Yes, I would have the confidence to say, ‘Well you either help me or you don’t’” C5969 interview, ST3, 29 January 2014 (p.95)</p> <p>“If it’s just snowing I’m fine. But once it starts getting a little bit slippery, I just refuse to go out, you know? I just haven’t got</p>	<p>a fall improved self-acceptance and confidence.</p> <ul style="list-style-type: none"> • Confidence is linked to slippery floor surfaces (e.g. ice) • The intervention was associated with improvements in confidence, independence, mood, activity levels, walking/balance, self-acceptance, and motivation, and reductions in anxiety. • Confidence associated with high level of fitness and running. • Fall associated with low confidence and high anxiety levels. • Reducing fear increased confidence. • Confidence link words: Fear, Fear of falling, Anxiety, Activity avoidance, Social isolation, Frailty, Self-efficacy, Self-perception, Independence, Psych, Activity, Balance, Falls risk, Knowledge, Self-acceptance, Mood, Motivation.
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	<p>that confidence for that yet, you know?" C3514 interview, ST3, 10 June 2013 (p.96)</p> <p>Client engagement with and understandings of the CBTi varied. Nevertheless, clients valued their interactions with the HCAs and perceived a range of benefits from the CBTi including improvements in confidence, independence, mood, activity levels, walking/balance, self-acceptance, and motivation, and reductions in anxiety. (p.107)</p> <p>Client engagement with, and understandings of, the CBTi varied. Nevertheless, clients who persisted with the CBTi valued their interactions with the HCAs and perceived a range of benefits from the intervention, including self-reported improvements in confidence and independence. (p.134)</p> <p>"On the sixth session he had reported a nasty fall, which gave the opportunity to discuss relapse prevention. This went very well with him getting back on his feet much faster than the last time he fell. His confidence had not suffered and it made him more determined to soldier on." (p.199)</p> <p>"This gentleman had experienced a very fitness-orientated lifestyle; he had been an active competitive runner and a lot of his confidence had had come from that." (p.202)</p> <p>"This resulted in a number of falls, lack of confidence and increased anxiety levels." (p.203)</p> <p>"Her confidence and independence had both increased and she was no longer afraid to put weight on her knee and felt less frightened." (p.204)</p>	
<p>Parry et al. (2014)</p> <p>A study protocol for a randomised</p>	<p>Many older individuals suffer from a variety of adverse psychosocial difficulties related to falling including fear, anxiety, loss of confidence and subsequent increasing activity avoidance, social isolation and frailty. Such 'fear of falling' is</p>	<ul style="list-style-type: none"> • Psychosocial sequela of falling include loss of confidence.


<p>controlled trial - The STRIDE (Strategies to Increase confidence, InDependence and Energy) study: A cognitive behavioural therapy-based intervention to reduce fear of falling in older fallers living in the community.</p>	<p>common and disabling, but definitive studies examining the effective management of the syndrome are lacking. (Abstract p.1)</p> <p>Many older individuals, both fallers and non-fallers, experience a variety of adverse psychosocial difficulties related to falling [5-15] including fear, anxiety, loss of confidence, and impaired self-efficacy (the self-perception of ability to perform within a particular domain of activities) [9,12] resulting in activity avoidance, social isolation and increasing frailty. (p.2)</p> <p>On the basis of current knowledge [16-19], we would expect anxious cognitions to be maintaining activity avoidance; physical tension and anxious cognitions to be interfering with walking; underactivity to be maintaining physical weakness and loss of confidence and/or competence. (p.5)</p> <p>[The Falls Efficacy Scale was developed] to explore different aspects of falls and balance confidence in individual patients through the medium of self-efficacy evaluation. (p.6)</p> <p>The main anticipated issue centres on the potential for patients to gain confidence and lose their fear of falling in a way that is inconsistent with their improvement (or lack there of) in physical function. (p.6)</p> <p>Functional reach is a good indicator of confidence in balance and increased risk of having a fall. (p.8)</p>	<ul style="list-style-type: none"> • Psychosocial factors associated with loss of confidence following a fall include fear, anxiety, impaired self-efficacy, activity avoidance, social isolation and frailty. • The behaviour repose to falling can include loss of confidence and/or competence. • The Falls Efficacy Scale (FSE) was developed to explore different aspects of falls and balance confidence through self-efficacy evaluation. • Intervention hoped to allow gain of confidence and loss of fear of falling with or without physical improvement. • Functional reach is a good indicator of confidence in balance • Confidence linked words: Fear, Anxiety, Activity avoidance, Social isolation, Frailty, Disabling, self-efficacy,
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		Competence, Balance.
<p>Parry et al. (2001)</p> <p>This paper evaluated test-retest reliability of the modified scales FES-UK and ABC-UK – two British variations on the North American Falls Efficacy Scale (FES) and the Activities-specific Balance Confidence scale (ABC).</p>	<p>Falls are common in older subjects and result in loss of confidence and independence. (Abstract p.103)</p> <p>While the physical and socioeconomic consequences of falls are relatively easily measured, the ensuing psychological morbidity and effects on confidence and independence are more insidious and less easily quantifiable (p.103)</p> <p>The terms “post-fall syndrome”¹³ falling”[5 10 14–16] or “fear of have been used to describe a loss of confidence and voluntary restriction on activity after a fall that is dramatically out of proportion to the physical injuries sustained.[5 14–16] (p.103)</p> <p>The ABC-UK is a 16 item scale which asks subjects to rate confidence regarding their balance and ability to remain steady when performing various tasks, from 0% (no confidence) to 100% (completely confident) in multiples of 10%. (p.104)</p> <p>The FES also asks individuals to rate confidence in performing daily activities by circling numbers from 1 (extremely confident) to 10 (no confidence at all) for 10 questions. (p.104)</p> <p>[ABC-UK Wording] For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the rating scale 0% to 100%, with 0% meaning you have no confidence and 100% meaning you feel completely confidence. (p.105)</p> <p>The falls literature offers several examples of randomised controlled trials where the number of falls and injuries and other physical descriptors are the main outcome measures,[26–31] with confidence and fear of falling playing a minor part in assessment. (p.107)</p> <p>[Article Learning Point]</p> <ul style="list-style-type: none"> Falls are common in older subjects and frequently result in loss of 	<ul style="list-style-type: none"> Falls result in loss of confidence and independence. The psychological effect of a fall on confidence and independence is less easy to quantify than physical and socioeconomic factors. Post-fall syndrome and fear of falling have been used to describe loss of confidence. Rating confidence in relation to balance (ABC). Rating confidence in relation to performing daily activities (FES). Rating self-confidence (ABC-UK). Falls are common in older people and frequently result in loss of confidence and self-efficacy. Confidence link words: Loss, Independence, Physical, Socioeconomic, Post-fall Syndrome, fear of falling, Activity restriction, Balance, Rating, Activities of daily

	<p>confidence and self-efficacy, the “cognitive mechanism by which the ability to control situations reduces stress”.</p> <p>[and]</p> <ul style="list-style-type: none"> Both modified scales were found to be reliable, valid, acceptable measures of falls related confidence and self-efficacy in older British subjects. (p.107) 	<p>living, Self-confidence, Self-efficacy.</p>
<p>Peduzzi et al. (2007)</p> <p>A study designed to evaluate the mechanisms of action in multicomponent physical conditioning programmes (driving assessments – PREHAB and DRIVER) for overall improvement in physical ability and/or self-confidence</p>	<p>In PREHAB, a measure of ADL self-efficacy was assessed at baseline and 7 months based on a modified version of the Falls Efficacy Scale [13]. Participants were asked how confident or sure they were about doing the following 10 activities: cleaning the house, getting dressed or undressed, preparing simple meals, taking a bath or shower, doing simple shopping, getting in and out of chair, going up and down stairs, walking around the neighbourhood, reaching into cabinets or closets, and hurrying to answer the telephone. (p.96)</p> <p>The findings that the PREHAB intervention operated through both improvements in physical ability and self-confidence confirmed the original secondary hypothesis of the trial. The justification for this hypothesis was based on a study by Mendes et al. [19] who examined whether high self-efficacy was protective against a decline in ADL functioning in community-living elderly persons. (p.100)</p> <p>Furthermore, to the extent that a perceived sense of frailty or physical slowness may increase anxiety while driving, an enhanced self-confidence about physical ability or speed of movement could decrease anxiety or increase focus on the task at hand. (p.100)</p>	<ul style="list-style-type: none"> Confidence is in the context of self-confidence. Confidence was measured on a falls self-efficacy scale. Confidence was measuring how sure participants were about doing activity of daily living tasks. Self-confidence improvement related to physical ability improvement. Self-confidence is linked to self-efficacy – high self- confidence and high self-efficacy. Enhanced self-confidence about physical ability or speed of movement could decrease anxiety or increase focus on a task. Confidence linked to words Self-confidence, ADLs, Self-efficacy, Function, Anxiety, Ability, Focus.

<p>Peel et al. (2000)</p> <p>A randomised trial of home safety assessment was examined as part of a of falls prevention intervention among older people living in the community.</p>	<p>While the effect on falls incidence of a home safety intervention on its own could not be demonstrated, other benefits, including improved confidence attributable to awareness of such falls prevention measures, were recorded. (Abstract p.536)</p> <p>While not demonstrating that home safety assessments and modifications significantly reduced falls and injuries in the population studied, other benefits such as improved confidence attributable to awareness of such falls prevention measures were recorded. Importantly, falls incidence rates were sustained, even lowered, a year after program interventions had ceased. (p.538)</p>	<ul style="list-style-type: none"> • Improved confidence through awareness of falls prevention measures. • Confidence linked to words: Falls, Awareness.
<p>Resnick (2002)</p> <p>A qualitative study exploring the influence of efficacy beliefs and motivation within a rehabilitation setting.</p>	<p>Specific outcome expectations were described as a belief that performing a certain activity would result in an expected outcome (i.e. participation in a rehabilitation will improve functional performance). This belief motivated individuals to participate in rehabilitation program.</p> <p>...it [the therapy] was just something that I believed I had to do. I didn't think about whether I could do it or not. I just knew that I needed to if I wanted to handle myself at home.</p> <p>...I am confident the therapy is going to help if I wasn't confident, I would not go to therapy, I would leave.</p> <p>... I was sure therapy would help, but I didn't think that I could do it. I gave it a try and I learned that I could do it. You can do a lot if you just try. (p. 154)</p>	<ul style="list-style-type: none"> • Confidence connected to seeing benefits. • Confidence linked to words: Motivation.
<p>Sandberg et al. (2014)</p> <p>A qualitative study exploring barriers and facilitators to understand complex case management interventions from the perspectives of older people</p>	<p>The [case manager] CM also experienced that different factors were important to gain this trust, such as time, continuity and personal chemistry. The confidence – often expressed as mutual confidence – was something that the CM valued highly and was seen as an important part of the intervention. (p.7)</p> <p>When the participants got the help and information they needed they felt confident in the CM intervention. This confidence could contribute to a strong</p>	<ul style="list-style-type: none"> • Confidence was often expressed as mutual confidence. • Participants felt confident when they received help and information. • Trust and confidence are important to build

and of case managers.	<p>relationship between the CM and the participant. (p.9)</p> <p>It was obvious that trust and confidence were crucial facilitators for performing the intervention and they permeated various categories. It is known that trust and confidence are important factors for building and maintaining a solid relationship between patients and caregivers [23-25] and are particularly important for older people with repeated health care contacts. (p.10)</p> <p>Mutual confidence and the participants experiencing trust, continuity and security were important elements and an important prerequisite for the case manager to perform the intervention and make a difference. (p.11)</p>	<p>relationships between the older person and the caregiver.</p> <ul style="list-style-type: none"> • Confidence link words: Trust, Relationships, Information.
<p>(Skymne et al., 2012)</p> <p>The study aimed to learn how frail elderly people experienced becoming assistive device users and how assistive devices affected their independence in daily activities.</p>	<p>Two themes emerged: Confidence in knowledge and experience and getting used to assistive devices in daily activities. Confidence in knowledge and experience was formed by two categories of experiences from the prescription procedure: trust the expert and trust yourself, and to have confidence in having the right information about assistive devices. (Abstract p.194)</p> <p>The two themes confidence in knowledge and experience and getting used to assistive devices in daily activities that emerged can be seen as parts of a pendulum (Figure 1). The base of the pendulum is illustrated as Confidence in knowledge and experience formed by the categories trust the expert and trust yourself, and have confidence in having the right information. The base symbolizes that confidence in knowledge and experience is a prerequisite for starting to get used to assistive devices.</p>	<ul style="list-style-type: none"> • Successful use of an assistive device was conditional on confidence in knowledge about the device and its use and practically using the device in daily activities. • Confidence in knowledge is informed by trusting yourself; trusting the expert and having confidence in having the right information. • Knowing your body can give confidence in challenging the experts to get the right assistive device. • Confidence link words: Knowledge, Experience,

	 <p>Figure 1. Confidence in knowledge and experience (illustrated as the base and Getting used to assistive devices as the top of the pyramid).</p> <p>(p.196-197)</p> <p>The theme confidence in knowledge and experience meant trusting the expert and themselves in matters concerning the need for assistive devices and having the appropriate one. It also meant confidence in having correct information on regulations and services surrounding assistive devices. (p.197)</p> <p>To trust yourself also meant it was important to trust one's own personal knowledge of one's body. This knowledge did not always match the expert's view. Thus, it was important to counter the experts with this and gain confidence in getting the assistive devices needed. (p.197)</p> <p>Confidence in having the right information implies the need for confidence in getting the necessary assistive devices without having to question the prescription. (p.198)</p> <p>To experience a prescribed assistive device as a means to independence in daily activities requires getting used to them. This is connected with confidence, in both the expert's and the participant's knowledge and experience. (p.200)</p>	Information, Trust.
<p>Tavakolan et al. (2011)</p> <p>A preliminary study investigation the viability of using surface electromyography hand control devices with older people.</p>	<p>Fear of frailty is a main concern for seniors. Surface electromyography (sEMG) controlled assistive devices for the upper extremities could potentially be used to augment seniors' force while training their muscles and reduce their fear of frailty. In fact, these devices could both improve self confidence and facilitate independent living in domestic environments. (Abstract p.1)</p>	<ul style="list-style-type: none"> • Assistive upper limb devices could improve self confidence in relation to independent living. • Confidence link words: Self-confidence, Independence, Frailty.

<p>Tung et al. (2013)</p> <p>A qualitative study exploring how older people maintain and improve their self-efficacy and adherence to rehabilitation exercise programmes following orthopaedic surgery at home.</p>	<p>Successful postoperative orthopaedic rehabilitation for older people depends on building their confidence about adherence to exercise programmes designed to improve their functional performance. (Abstract p. 1217)</p> <p>Findings emphasise the importance of social support from family, friends and community to nurture self-efficacy. Accessing personal beliefs and attitudes, adaptive strategies and goal setting were all sources and ways participants rebuilt their confidence and motivation in regard to adhering to a rehabilitation programme. (Abstract p. 1217)</p> <p>There is often a reduced level of confidence and motivation in patients following discharge from orthopaedic surgery. (p, 1218)</p> <p>Three major themes emerged from the data: (1) nurturing self-efficacy through working with others, (2) strengthening self-efficacy through accessing personal values and beliefs and (3) improving self-efficacy through adaptive strategies and goal setting. These themes illuminate the important resources and strategies older people use to sustain personal efficacy beliefs and to preserve higher confidence levels to maintain daily activities and manage home rehabilitation. (p.1220)</p> <p>As a result, all participants accepted nurturing support from their social network or sought assistance from community services to gain more confidence in dealing with their situations. (p. 1220)</p> <p>Participants were able to improve their self-efficacy in relation to their rehabilitation programme at home through adaptations and modifications made to daily activities and by setting goals to continue their normal lives and activities. These consequently increased their overall confidence in managing challenging situations within the rehabilitation process enabling them to</p>	<ul style="list-style-type: none"> • Confidence building through exercise adherence, self-efficacy similarity, social network connected, goal connected, walking aids, being taught, independence giving. • Confidence link words: Motivation, self-efficacy, social networks, goals, education, independence.
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	<p>gain success in their home rehabilitation goals. (p.1221)</p> <p>Participants used various walking aids and facilities, depending on individual capability, to improve confidence with situations and environments. They thought that this allowed them to continue with their independent living, improve their self-efficacy towards adhering to their rehabilitation programme and improve their quality of life:... (p.1222)</p> <p>“Well, when I first came home and I had a walker, you know and I walked around here and I hated it. But it gave me great confidence. It really did give me confidence ...” (Diana) (Quote p. 1222)</p> <p>Although all participants had reached a satisfactory level of independence in functional performance, they continued to experience various challenges and felt low in confidence in continuing a home rehabilitation programme. They expressed feelings of frustration, fear, nervousness and being impatient with their progress. (p. 1222)</p> <p>These support networks enabled participants to gain confidence in their capabilities that nurtured their self-efficacy to adhere to the rehabilitation programme. (p. 1223)</p>	
<p>(Underwood et al., 2015)</p> <p>A systematic review study protocol of qualitative research aiming to discover the meaning and understanding of confidence as experience by frail older adults.</p>	<p>Connecting to and clearly understanding the notion of confidence related to maintaining mental well-being and physical health as experienced by this older population who are living with frailty is important. (p.63)</p> <p>The impact of an individual losing their “confidence” results in additional health and care staff contact time and resources to meet a deficit between a person’s “loss” and their actual or perceived need. (p.63)</p> <p>Consequently, “confidence” is commonly spoken about in our care settings when in contact with older people, but as a notion, it is not clearly understood. (p.63)</p>	<ul style="list-style-type: none"> • There is an important need to relate confidence to maintaining wellbeing for older people living with frailty. • Losing confidence is associate with additional health and care resources. • Confidence is commonly spoken about in practice.

	<p>An individual's "confidence" is often made reference to in practice; similarly, it is quite commonly commented on in the healthcare literature. (p.63)</p> <p>Confidence and self-efficacy are often used interchangeably or they merge in explanations. (p.63)</p> <p>Wallston describes his concept of "perceived competence", a generalized theoretical perspective of self-efficacy, as "self-efficacy reflecting one's confidence in performing goal-oriented behaviors across situations." [9(p149)] (p.63)</p> <p>It becomes important to interpret what confidence really means to an individual and what specifically can be done by health and care staff, or by the systems they work within, to maintain and grow this "confidence", or "self-efficacy", as we see a significantly growing number of older people living with frailty and dependency in the world. (p.63)</p> <p>No systematic reviews exploring confidence, frailty and mental well-being and physical health were located. (p.63)</p> <p>They importantly identified "loss of confidence" as a recurrent phase being used in the context of an individual's dealings with the impact of their physical health deterioration over time on their psychological and social well-being. (p.63)</p> <p>Viljanen et al.[11] report the impact of "sensory loss" and how the fear of falling jeopardizes an individual's confidence; whilst "loss of social contact"/"social isolation"/"loneliness" is reported by a number of authors.[5,12-16] (p.63)</p> <p>"Technology's" influence in boosting confidence is reported in papers. (p.64)</p> <p>Other literature identifies confidence as being impacted on by "mental health concerns" such as:</p>	<ul style="list-style-type: none"> • Understanding in practice of what confidence means is not clear. • Confidence is commonly mentioned in healthcare literature. • Confidence and self-efficacy are often used interchangeably. • Self-efficacy reflects one's confidence in performing goal-orientated behaviours. • It is important to interpreting what confidence means for older people. • Maintain and growing confidence in the frail older population is important as the world's population grow older. • Loss of confidence is associated with dealing with the impact of physical deterioration over time on their psychosocial well-being. • Fear of falling (associated with sight loss) jeopardises confidence. • Confidence loss is associate with loss of social
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	<p>“anxiety”[24,25,] “anxiety and depression”[26] and “stress”. [27,28] (p.64)</p> <p>“Loss of confidence” is also a term prominent within falls literature, and is found alongside “loss of independence”. It is connected to “fear of falling” and “loss of balance confidence”. [29-31] (p.64)</p> <p>It is recognized that periods spent on the floor, when the person is unable to get up following a fall or waiting for help, are particularly undermining to an individual’s confidence. (p,64)</p> <p>Psychologist Albert Bandura comments that “confidence” is a colloquial term: a catchword rather than a construct embedded in a theoretical system. (p.64)</p> <p>Bandura goes on to dismiss “confidence” as a nondescript term that refers to strength of belief, not specifically about the certainty about the belief. (p.64)</p> <p>Walker, in describing a new theory of control, associates perceived control to a person’s confidence and optimism. (p.64)</p> <p>Given the growing numbers of this population world-wide, a systematic review on this topic is urgently needed since evidence-based guidance, which can be used to inform practice based support to older people who have lost confidence, or for whom it is recognized that the maintenance of confidence is crucial for their well-being, is currently limited. (p.64)</p>	<p>contact, Loneliness and social isolation.</p> <ul style="list-style-type: none"> • Technology can be confidence boosting. • Confidence impacts on mental health: associated with anxiety, stress, depression. • Loss of confidence is associated with Loss of independence and Loss of balance confidence. • Time post fall spent of the floor unable to get up has an undermining effect on confidence. • confidence” is described as a nondescript term that refers to strength of belief. • One theory associates perceived control to a person’s confidence and optimism. • Maintenance of confidence is crucial for well-being. • Confidence link words: Fear of falling, Sensory loss, Social isolation, social contact, Self-efficacy, Loneliness, Maintenance,
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<p>(Underwood et al., 2017)</p> <p>A qualitative systematic review exploring the meaning of confidence for older people living with frailty.</p>	<p>Within healthcare literature “loss of confidence” is occasionally connected to older people living with frailty, but ambiguously described. Understanding the concept of confidence within the context of frailty could inform interventions to meet this growing challenge. (Abstract p. 1316)</p> <p>The objective of this systematic review was to explore the meaning of confidence from the perspective of older people living with frailty through synthesis of qualitative evidence to inform healthcare practice, research and policy. (Abstract p. 1316)</p> <p><u>Phenomena of interest</u> The concept of “confidence” and its impact on the physical health and mental well-being of older people living with frailty. (Abstract p. 1316)</p> <p><u>Context</u> Studies that reported on the older person’s descriptions, understanding and meaning of confidence in relation to their frailty or recent healthcare experiences. (Abstract p. 1316)</p> <p><u>Conclusions</u> Assertions that an understanding of the concept confidence has been reached cannot be made. The review data offer limited insight into the concept of confidence being described by the cohort</p>	<ul style="list-style-type: none"> • Confidence loss is occasional connect to older people living with frailty. • Connected to health decline over time and psychosocial well-being. • Connected with fear of falling, loss of social contact / social isolation / loneliness. • Technology can boost confidence. • Linked to new skill development. • Mental well-being connections exist. • It is connected to self-belief, independence and social connectedness. • It is fundamentally connected to vulnerability. • Confidence linked words:

	<p>of older people living with frailty. (Abstract p. 1316)</p> <p>The effect of physical well-being is more clearly understood than that of mental well-being at this time. Based on the concept of confidence, this population of older people living with frailty, particularly in the context of acute hospitalization and post-acute care, is becoming a high priority for service providers and policy makers. However, within healthcare literature, the concept of confidence in this context is hard to unearth and seems ambiguous, and when found is mostly researcher/author-centric in the descriptions. (p. 1318)</p> <p>No systematic reviews exploring confidence, frailty and mental well-being or physical health were identified. (p. 1318)</p> <p>An individual's confidence is observed in the healthcare literature in one of only a few ways: relating to a concrete or conceptual loss; in falls literature linked to a person's fear of falling; or connected to one or two mental health and wellbeing concerns. (p. 1318)</p> <p>Nicholson et al.,²⁰ exploring the experiences of older people living with frailty, identified "loss of confidence" as a recurrent phase being used in the context of an individual dealing with the impact of their physical health deterioration over time and on their psychological and social well-being. (p. 1318)</p> <p>By far, the literature relating to confidence and loss sits outside qualitative research paradigms but may give contextual insights to aid future search strategies. (p. 1318)</p> <p>These include Viljanen et al.'s²¹ report on the impact of sensory loss and how the fear of falling jeopardizes an individual's confidence, whilst loss of social contact / social isolation / loneliness has been reported by a number of researchers.²²⁻²⁷ (p. 1318)</p>	<p>Loss, Health, Psychological, Social, Well-being Fear of falling, Loss of social contact, Social isolation, Loneliness, Balance, Technology, Skills, Self-efficacy, Anxiety, Depression, Vulnerability, Belief, Self-belief, Social connectedness, Independence, Frailty.</p>
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	<p>However, this is discussed predominantly in the literature about skill development, promoting confidence.²⁹⁻³¹ Technology's influence in boosting confidence has also been reported.^{22,32-34} (p. 1319)</p> <p>What comes over strongly is the impact of an individual losing their confidence resulting in additional healthcare staff contact time and resources to meet the deficit between a person's loss and their actual or perceived need. (p. 1319)</p> <p>This loss of confidence is also prominent within the falls literature and is found alongside loss of independence. It is connected to the fear of falling and loss confidence in balancing.³⁵⁻³⁷ Such psychological and social consequences of a fall are seen as the start of a vicious cycle that leads to reduced activity, physical functioning and further increased risk of falling.³⁸ It is recognized that periods spent on the floor, when the person is unable to get up following a fall or is waiting for help, are particularly under- mining to an individual's confidence.³⁹ (p. 1319)</p> <p>Psychological and mental well- being aspects of confidence are reflected in other academic work, often connected to falls studies.⁴⁰⁻⁴⁴ These articulate connections to the concept of confidence that are either un-explored or used interchangeably with the established concept of self-efficacy,⁴⁵ for example, anxiety and depression relating to balance confidence⁴⁰ or perceived behavior control being referred to as confidence, when looking at psychosocial factors that could be developed to support older peoples' participation in physical activity programs.⁴⁴ (p. 1319)</p> <p>Finally, it cannot be over emphasized that the preliminary searches that informed the systematic review's protocol development⁴⁶ found no narrative to inform the meaning of confidence from</p>	
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	<p>the perspective of an older person living with frailty. (p. 1319)</p> <p>The nature of the research found identified that the term confidence was referenced more often in quantitative literature relating to assessment of falls confidence, for example, than it was in qualitatively grounded research. It therefore appears that there is minimal evidence on the meaning of confidence as a term that is commonly used in clinical practice. (p. 1319)</p> <p>It helps if we have clues on how to interpret what confidence really means to an individual and what specifically can be done by healthcare teams and communities to maintain and grow this confidence, especially in the light of significant growth in the number of older people living with frailty and dependency across the world. (p. 1319)</p> <p>This review was required to inform evidence-based guidance which can be used to develop clinical practice interventions with older people who have lost confidence, or for whom it is recognized that the maintenance of their confidence is crucial to well-being and healthy living. (p. 1319)</p> <p>Seven studies cited “confidence” in their abstract, directly attributable to an expressed older person’s viewpoint.^{34,51-56} Seven additional studies were assessed to have a high probability of documenting an older person’s voice expressing a meaningful description of confidence as they deployed methodological approaches where quotes of research participants would be expected to be expressed.⁵⁷⁻⁶³ (p. 1319)</p> <p>Beesley’s study^{66(p2350)} “...your confidence has been knocked around a fair bit...” and Research Participant ^{566(p2351)} “...[stroke] knocks your confidence for six...” These two direct quotes have a negative preposition of what confidence means. (p.1327)</p>	
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	<p>"It really helped build up your confidence (to the point that I) can get up."^{65(p.154)} This can clearly be seen to relate back to the categories – independence and belief as it informs the synthesized finding of Vulnerability. (p.1328)</p> <p>Describing her transition back home, she said: "I had my daughter come and do the work for the first week, look after me, stay with me ... she did everything. She was a great help. ... you know that was what I needed to have someone here with me for the first week and then I said you can go home because I was more confident and you didn't need to be here."^{31(p1220)} An initial vulnerability, where confidence was low, was overcome through physical and practical assistance given by her daughter. A growth of physical and psychological well-being brought about a confidence to no longer ask for such help. The social connectedness finding is obvious. (p.1328)</p> <p>When exploring additional validity, a comparison of the contextual definition, as illustrated above, it is useful to consider it against a dictionary definition: "Vulnerability – able to be easily physically, emotionally, or mentally hurt, influenced, or attacked".⁶⁹ This reflects a negative impact and does not mention any social paradigm. Noticeably, from the four studies, two very directly identified wider social associations linked to confidence.^{31,66} (p.1328)</p> <p>A biopsychosocial⁷¹ connection to health and wellbeing is reflected in the review's three emergent categories from study findings that aggregated the final finding – Vulnerability (Table 4). The category "Belief" recognizes the emotional/psychological desire to achieve a goal; in the category "Independence", the connection of confidence to (bio)physical/functional as well as emotional constructs was evident in participants' narratives (these were often referred to as self-efficacy), and finally the category "Social connectedness" acknowledges how the social domain</p>	
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	<p>interplayed on confidence and the other categories. (p.1328)</p> <p>This review recognizes that the topic of confidence is referred to across a wide range of literature connected to older people, many living with frailty. However, the meaning and understanding of confidence remains contextually unexplored in the literature. Without truly knowing what the concept means, much goes misinterpreted and misunderstood. This opens an opportunity for an integrative research program to address the paucity in literature that this review highlights, including the concept of confidence, that is, one drawn from older people living with frailty. This concept needs developing as it would allow detailed exploration of the relationship between confidence and frailty. In-depth understanding will lead to insights into new frailty prevention and intervention strategies. (p.1328)</p> <p>Furthermore, the question – could a restoration of lost confidence reverse frailty or stall its progress? – presents an area for further academic enquiry, as developing measures of confidence in this frail population could assist health care professionals and services to make a positive impact on interventional work across frailty pathways of care. (p.1328)</p> <p>As discussed earlier, the review did not identify voices of the frail older people that could provide meaning and understanding of the concept of confidence. The synthesized findings of this review were drawn from just four research studies that met the inclusion criteria. Therefore, claims that an understanding of the concept confidence has been reached cannot be made. The review data offered limited insights into the concept of confidence as described by the cohort of older people living with frailty. Identifying frailty amongst research participants was more difficult to determine than expected, even with very clear definitions. (p.1328)</p>	
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<p>Wallin et al. (2007)</p> <p>Qualitative research study exploring the meaning older people give to their rehabilitation experience</p>	<p>Semi-structured interviews were analysed using a qualitative method, which identified three categories of meaning. In the category 'sense of confidence with everyday life ' (Abstract p. 147)</p> <p>Three categories of the meaning of rehabilitation were inductively formed from the analysis of the interviews: sense of confidence with everyday life, sense of vacation and sense of disappointment in the rehabilitation programme. Each participant's account was allocated to one of the three categories, which are here illustrated with verbatim excerpts. (p. 151)</p> <p>This category 'sense of confidence with everyday life ' included the participants' expressions of the various benefits that they perceived from the rehabilitation. Many of these were framed in a coherent story that described incidents in their lives that were challenging or had caused problems. They felt that the rehabilitation intervention would help them cope at home. The perceived benefits were interwoven with senses of being able to take care of oneself, of coping with everyday life, with improving physical abilities, and with experiencing encouraging interactions with the staff. The participants said that they had gained confidence in their own abilities and resources, which reinforced their capability to cope with everyday life at home. Moreover, they reported a new boldness to participate in activities, and revived enthusiasm to try harder and not give in. (p. 152)</p> <p>Furthermore, the improved physical ability carried over to independent living at home. For example, in the following quote the participant describes his improved self-confidence to live alone without home-health services. Prior to the rehabilitation, a health visitor came twice a day, but after the rehabilitation he felt that he no longer needed regular nursing attendance:</p> <p>Q: If you consider the meaning of this spell in rehabilitation in terms of how you</p>	<ul style="list-style-type: none"> • A sense of confidence with everyday life, connected to rehabilitation process, own abilities and resources, able to cope better, Physical ability, ability to live independently, confidence with others. • Confidence link words: Ability, Cope, Boldness, Independence
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	<p>can manage at home, what in your opinion have been the benefits? A: Well it's been pretty good, it's given me a lot of confidence. You began to feel you can cope on your own...without help. Like these nurses no longer have to come round twice a day, not even once. So it's given (me) the confidence to cope without help at home. (p. 151-152)</p> <p>Reciprocal interaction with the professionals in the rehabilitation centre seemed to improve the participants' confidence in their ability to cope at home. They described having conversations with the doctor and physiotherapists, who listened to them, encouraged them and helped them find new solutions. The following exchange exemplifies a constructive interaction between the participant and the physiotherapist: Q: Whose idea was this that you practised these kinds of things? A: Well it was getting out of a chair, this was what they were teaching us. We used a higher chair and then next a lower one...and then I said that I'll fall over and I won't be able to get up. And then we started talking, and they asked me, 'Should we practise this?' and I said 'absolutely'. And then we tried it, several times, and every day it went better and better. It really helped build up your confidence (to the point that I) can get up. (p.154)</p> <p>In these cases, the participants expressed confidence with their therapists' expertise to detect their unique needs and to modify the exercises accordingly. (p. 154)</p> <p>The category 'sense of confidence with everyday life' exemplified the route to successful goal attainment, as perceived by the participants. Three interwoven aspects of a beneficial rehabilitation experience were described: increased confidence in one's capability to cope at home, improved physical ability, and positive reciprocal interactions with the staff. (p. 159)</p>	
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	Furthermore, the finding that the interactions with staff gave some participants enhanced confidence that they could cope at home also corroborates previous evidence, for it has been shown that positive partnerships and a sense of control in health-care encounters enhance chronically-ill adults' wellbeing (Kettunen, Poskiparta and Liimatainen 2001; Sullivan, Weinert and Cudney 2003). (p. 159)	
Williams and Ho (2004) Book Chapter: Balance and Postural Control across the Lifespan	Frail elderly fall even more frequently and suffer serious injuries and hospitalisation as a result. For all ages, lack of appropriate control of balance and posture can have a negative effect on both mental and physical health: these effects are manifested in a variety of ways and include loss of confidence in ability to perform physical tasks, loss of independence, withdrawal from social activities and diminished self-image and self-esteem. (p.211)	<ul style="list-style-type: none"> • Lack of appropriate control of balance and posture can have a negative effect on confidence in ability to perform physical tasks. • Confidence link words: Physical tasks, independence, social activity, self-image, self-esteem.
Yardley et al. (2007) This study set out to develop recommendations to promote the uptake of and adherence to falls-prevention interventions among older people.	<p>[Table 2 Recommendations for promoting uptake of falls-related interventions]</p> <p>2. When offering or publicising interventions, promote immediate benefits that fit with a positive self-identity. (Examples of benefits that are highly valued by older people include increased independence, confidence in functional capabilities and proactive self-management of health.) (p.232)</p> <p>[Evidence for the above recommendation]</p> <p>The reasons older people give for undertaking strength-training and balance-training focus on the many immediate benefits compatible with a positive identity (eg interest, enjoyment, increased confidence, maintaining general health, mobility and independence) rather than reducing the risk of a possible fall sometime in the future.[6,10,20] (p.232)</p>	<ul style="list-style-type: none"> • Older people value falls related interventions for their ability to increase confidence in functional capabilities. • One reasons older people give for undertaking strength-training and balance-training programmes is that they increase their confidence. • Selecting activities in falls related interventions

	<p>[Table 3 Recommendations for promoting uptake and adherence to falls-related interventions]</p> <p>5. Encourage confidence in self-management rather than dependence on professionals, by giving older people an active role.(p,233)</p> <p>[Evidence for the above recommendation] Giving the individual an active role in selecting activities and setting goals increases motivation and self-efficacy (ie, confidence in the ability to carry out a behaviour), which in turn promotes adherence.[21,27] (p.233)</p> <p>[Table 3 Recommendations for promoting uptake and adherence to falls-related interventions]</p> <p>6. Draw on validated methods for promoting and assessing the processes that maintain adherence, especially in the longer term. (These could include encouraging realistic positive beliefs, assisting with planning and implementation of new behaviours, building self-confidence, and providing practical support.) (p.233)</p> <p>[Evidence for the above recommendation] Findings from research (mainly qualitative) on attitudes to falls prevention interventions suggest that uptake and adherence are indeed influenced by factors identified as important to adherence to other therapies,[1] such as practical support, encouragement from therapists, the belief that the intervention is necessary and effective, and confidence in being able to carry it out.[6.11] (p.233)</p>	<p>and setting goals increases confidence in the ability to carry out a behaviour and promotes adherence.</p> <ul style="list-style-type: none"> • Building self-confidence helps maintain adherence to falls related interventions. • Confidence to carry out an intervention is connected to adherence in falls relate interventions and are influenced by the therapist.. • Confidence link words: Self-identity, Independence, functional capabilities, Self-management, Mobility, General Health, Motivation, Self-efficacy, Self-confidence, Beliefs, Behaviours, Attitudes,
<p>Yardley et al. (2006)</p> <p>The aim of this study was to gain an understanding of older people's perceptions of falls prevention advice, and how best to design</p>	<p>Research has shown that older people fear falling and restrict their activity not simply to avoid physical consequences such as injury and loss of independence, but because they are concerned about the social consequences of falling for self-image and self-confidence—for example, the embarrassment of being seen to lose control [6]. (p.509)</p> <p>[Research participant quote]</p>	<ul style="list-style-type: none"> • The social consequence of falling affects self-image and self-confidence. • Information can give confidence. • A fall can take your confidence away.

<p>communications that will encourage older people to take action to prevent falls.</p>	<p>I think it would give me more confidence of building up your balance if I read this [leaflet about improving balance] now. I think it would give me more confidence when I'm out. (p.511)</p> <p>[Research participant quote] At my age the last thing I want to do is, every time I want—I've got to be careful, I mustn't step there'. I'm sorry, you know, you just don't want to be thinking all the time. I mean I'm finding now that because I've just had a fall, it takes your confidence away, there's nothing worse than that ... The last thing you want as you get older is to be told that you've got to be conscious every time you go out and might fall, you don't want that, otherwise your life's gone. (p.514)</p> <p>Advice to ask for assistance rather than undertake risky activities was also seen by some participants as an unacceptable loss of independence and self-confidence. For example, one female participant aged 82 years, who said that her husband would not allow her to stand on a stool to clean the windows, simply did this when her husband was away, because: I've got a horror of having to reach the day when I've got to rely on someone else. (p.514)</p> <p>This emphasis on balance improvement rather than hazard reduction would be likely to increase confidence in balance rather than provoke anxiety about risk, with potentially beneficial consequences for activity levels [32], which in turn may have a positive effect on physical functioning and falls risk [33]. (p.515)</p> <p>Messages about how balance and mobility could be improved were usually regarded as useful and relevant by our participants, and so a lifespan approach to 'improving posture and balance' or 'increasing freedom and confidence in movement' may prove a more attractive goal than 'falls prevention in later life'. (p.515)</p>	<ul style="list-style-type: none"> • Advice given to ask for assistance was seen to take away a person's confidence. • Emphasising balance improvement rather than hazard reduction would likely increase confidence in balance. • Falls intervention programmes titles could change from: 'falls prevention in later life' to 'increasing freedom and confidence in movement'. • Confidence link words: Fear of falling, Self-confidence, Self-image, Independence, Loss of control, Information, Balance, Freedom, Movement,
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Appendix 3: Detailed phenomenological analysis of six older participants interviews

Participant 02 – Detailed phenomenological analysis

1. Individual interview analysis

You lose confidence following a fall and when you lay there and cannot get up, but it's hard to explain. Lying there on the floor, you have a strange empty feeling, your confidence just takes something away. Confidence is about regaining something you have lost. It is connected to the need or desire to do something, something about the situation you are in. In your mind you cannot do these things – You have the desire, but not the confidence. It might be down to nerves and worrying about falling again.

Nervousness plays a part in your confidence. You can struggle to let go, letting go of the help and support intermediate care services have offered this last six weeks and worrying what that might mean. There is a nagging you in your mind to keep some level of support going, it may be lonely otherwise, you might not manage. That nagging maybe more a fear of letting go and becoming dependent on just yourself again.

Confidence starts to grow as you start to achieve things, being less dependent on carers for example. As you become more independent you don't need them to call in and support you as much. However, this contrasts with that struggle you have too, to feel confident to let go. Becoming less dependent on others is an achievement that helps your confidence to grow. It is a struggle to mentally get there, but you are determined to do so. Confidence is something you must work at. It builds as you achieve things, like walking well with your frame. You balance wanting to do well with a fear of just doing it, it is scary.

Unique (incidental) themes: (bold are stronger themes)

Falls affect your confidence

Confidence means regaining and building back something you have lost

You become confident when you achieve what you desire

Being fearful (of falls and of loneliness) has a negative effect on confidence

2. Meaning and understanding review

Falls affect your confidence

...can you recall a time when you have lost your confidence...?

Yes, well I have lost it a bit now.

Okay...

Because of the falls and I still have. And I'm not really back to how I used to be and I don't know whether I really will be because I have got little bit older.

Losing your confidence, you see (.) yes, its if (.) I can't explain exactly. (P02 Starts line 29)

Falling again (.) and your legs get wobbly. This is all part of the (.) and worry I suppose (.) and worry is all part of it. (P02 starts line 69)

...just looking at my notes, you said to me in hospital that you've regularly lost your confidence at home over these last months...?

Well yes, I have fallen. I have had two or three falls you see.

Right I see, its related to falls?

Yes, ... I have never broken anything. But I haven't been able to get up you see, I have fallen over. That's frightening in itself I suppose.

Yer (...) What's it like to lose your confidence after a fall? What does that feel like?

(.) well sort of strange empty feeling I suppose, urm, well I suppose it's fright (.). (P02 starts line 144)

Confidence means regaining and building something you have lost

Well regaining the (.) well I was going to say confid- regaining the...regaining something that you've lost. (P02 starts line 39)

Well it's sort of desire to do something... (P02 line 44)

...would desire be the right word? (P02, line 46)

(...) well the need I suppose... yes... (P02 line 48)

(...) to regain something that I've lost... (P02 line 50)

...determination that's the word I'm thinking of. Yes, I'm determined to get better...

Yes.

...It's a struggle. (P02 starts line 105)

You become confident when you achieve what you desire

...in my mind I think I can't do these things (.) I think that might be able to explain some of it (...) I haven't lost the desire. I still have the desire to want to do it, but I haven't got the confidence. (P02 starts line 59)

I think I uh (.) want to do something I can't achieve. Thinking I'll reach over there, and I'll get that (.) I know is sort of, 'I can't do that', 'Oh yes I will' sort of thing. (.) The desire to do something but I can't do it. (P02 starts line 75)

...well achieving something more. Urm, obviously, I've got to walk with a frame and I've got to walk with something, err, (...) I just hope I get back my confidence, my confidence will come back... I suppose as I said before the word desire. A strong desire to do something more but then (.) I'm a bit frightened of doing it. (P02 starts line 85)

I've given them coming up in in the mornings, so I must be doing something. Cos I've got the desire and I'm...I...I'm independent really you know I want to do that. (P02 starts line 95)

I'm giving up the morning times. so that's achieved something I suppose. (P02 line 98)

Being fearful (of falls and of loneliness) has a negative effect on confidence

Falling again (.) and your legs get wobbly. This is all part of the (.) and worry I suppose (.) and worry is all part of it. (P02 starts line 69)

I know I can do it but then I am scared to do it (.) and that where I have lost my confidence. (P02 starts line 91)

...because they say you're coming in in the morning, why are we bothering to come in because you are dressed and so (.) I suppose that is a step forward and that's what they are supposed to be doing, that [Intermediate Care Service]. But I don't have the confidence again to say don't come any more (.) not the sort of afternoon, the evening one I quite look forward to that one... (P02 starts line 111)

What's holding you back then, to say, to, to keep them coming in...

...fright. (P02 starts line 118)

I don't mind being left alone I, I just don't know. Perhaps it is the fright of being left alone...

Or is it anything else?

No.

I don't want to put words into your mouth, its...

No, but they can (.) they say good night and I can get myself to bed and all that sort of thing... (P02 starts line 123)

Sometimes I think I'm better just left to get on with it now err, you know, 'You can do it, just get on with it' (.) right, which I hope I will soon. There's something, a little something at the back, a little bit nervousness... (P02 starts line 131)

Have a think, what do you think that niggle is that says, that says I'm not quite ready...?

Fright, yes...

...its being frightened?

Yes, I suppose that covers it. (P02 starts line 138)

What's it like to lose your confidence after a fall? What does that feel like?

(.) well sort of strange empty feeling I suppose, urm, well I suppose it's fright (.) (P02 starts line 152)

3. Guided existential inquiry

Lived body: Physical falls are central to this participant's lived-experience of confidence. Her *wobbly legs* (Line 69) are referenced as is her *overreaching* that has causes her to fear a fall (Line 75), both bodily connections to confidence affecting falls. There is a constant narrative through the conversation linking her battle with frailty to the ambition of regaining her physical independence.

Lived space: The participant's internal space is most evident in this conversation, her mind's role in overcoming this lived fear of falling is ever present. She talks it through to herself throughout the conversation: '*I can't do that, oh yes I will*' (Line 76); '*I've got to walk with a frame ... my confidence will come back*' (Lines 85 and 87); and '*I've got the desire ... I'm independent*' (Line 96). There seems a perpetual mind game of confidence prompting, of promotion and management connected to her lived-experience of confidence.

Lived time: The only connections to time and confidence is recalled in her seeing herself age:

Because of the falls and I still have. And I'm not really back to how I used to be and I don't know whether I really will be, because I have got little bit older. Losing your confidence, you see (.) yes, its if (.) I can't explain exactly. (P02 starts line 33)

Exploring a little about health and frailty in the last couple of years she recognises her ambitions are not always as achievable: '*...of course I've got older ... I can't achieve what I want to (...) and that is annoying in a way*' (Starts line 166).

Lived self-other: This participant lives alone and mentions no others apart from the temporary carers visiting her from the intermediate care service. She describes, without being explicit, the worries of recovery being balanced with a loss of social contact. Confidence is entwined within this. She is clear confidence grows as you become independent and as you set your goals (your desires) to achieve. She worries about the withdrawing service staff. The sentence where she mentions missing them '*say good night*' (Line 128), really connects to the deep tension she faces, and sadness for a loss of social (of human) connection.

Lived things: In some way the entity of the intermediate care service that is attending her three times a day is seen in the conversations as a material lived-experienced connected intrinsically to her confidence. It holds confidence giving opportunity to meet her ambitions for independence with the negative aspect as dependency on the services poses a significant wrench when withdrawn. This contradictory emotional or psychological dependency that grows and maybe dependency is realised throws up the complexity of this this lived-*thing*. Confidence is connected throughout this singular lived-experience of the intermediate care services. These services can be seen as societal or political *things*, responding to moving care from centralised and costly institutions (hospitals) to our more personal concern, those of our own homes, back in our communities.

Participant 03 - Detailed phenomenological analysis

1. Individual interview analysis

Confidence means being independent and physically well. Confidence is affected by a fall and is connected to the inevitability of getting older and frailer. You lose your confidence when you fall, each fall takes a little bit more away and with it you lose your judgement. Losing your judgment, negotiating the home environment with poor confidence makes you hesitant, you are thinking about tripping over and seeing the things you can trip over, it is there all the time.

You can be particularly hesitant and lack confidence when going up and down stairs, especially when you are feeling weaker and less strong following a fall. Being taught techniques on how to get up and down stairs and using your stronger leg to steady you, gives you confidence – a feeling ‘you can do it’.

Losing your confidence or having your confidence knocked after a fall makes you more vulnerable. Dealing with or managing the things you used to do before becomes more difficult. You worry about falling again. Building your confidence takes a while to do. You have to start building yourself up, rehabilitating yourself and setting out what you need to achieve next to see progress – goal setting. Your confidence grows when you set personal goals and you achieve them. Your confidence can grow with determination.

Unique (incidental) themes: (bold are stronger themes)

Confidence is connected to being independent

Confidence loss is caused by falls

Lacking confidence makes you more hesitant

Losing your confidence makes you more vulnerable

Teaching you new ways to manage helps your confidence grow

Building your confidence takes a while.

Confidence can grow by setting yourself goals to achieve.

Confidence can grow with determination.

2. Meaning and understanding review

Confidence is connected to being independent (not frail)

Well it means to be independent and not have to rely on too many people, er, for help. (P03 start line 6)

But you said it feels inevitable [frailty] as you get older?

Yes, it does, I mean unless you have been a very physically active person you are bound to er, have that problem as you get older. I mean, there was a woman in the next bed in hospital to me, she was ninety-five. Then she played golf for years, that's bound to help her deal with any frailty. (P03 starts line 66)

Confidence loss is caused by falls

Can you recall a time where you've felt your confidence lost or...?

Yes, each time I had a fall...

Right.

Each time I had a fall it took away a lot of my confidence... (P03 starts line 10)

Lacking confidence makes you more hesitant

...it took away a lot of my confidence...

Right.

...in my ability to judge, er (...) whether I was, er, responding properly to the (...) the things around me. Such as, watching out for that extra step or watching out for that chair leg I fell over... (P03 starts line 13)

How do you recognise your confidence has gone?

I'm more hesitant (...) more hesitant. So that tells me my confidence is not good at the moment and I'll need to build it up. (P03 starts line 22)

I was hesitant about going up and down the stairs. Er, really I didn't say a lot as I was concentrating as I was going up and down the stairs. (P03 starts line 31)

...a situation that I thought I could deal with in the past I find I'm not so good at dealing with. Like, falling over things or falling down stairs (...). (P03 starts line 54)

Losing your confidence makes you more vulnerable

Are there any other times when ... you have felt confident or lost confidence?

Not really...

Apart from the falls?

Not really, no.

No?

I don't think I'm that kind of person, is I? [asking daughter]

[Daughter responds] Not really, I think the falls have knocked your confidence.

That's basically it – vulnerable. (.) That's it.

Vulnerable is an interesting word – what do you mean by it?

I mean that, er, a situation that I thought I could deal with in the past I find I'm not so good at dealing with. Like, falling over things or falling down stairs (...). (P03 starts line 44)

Teaching you new ways to manage helps your confidence grow

...in hospital you talked about your confidence being lost to a physiotherapist, relating to your fall?

Yes, it was with two physios that were teaching me how to go up the stairs. (P03 starts line 27)

...I was picking up certain things I was told to do when I was climbing up and down stairs.

What sort of things were they?

Well, er, going up you use your good leg and coming down you use your bad leg. Which made going up and down stairs easier.

Good, so you were able to do it easier?

Easier, because of that...

And that had an impact on your confidence? or was that...

It gave me confidence to use that system, it was easier to get up and down the stairs. (P03 starts line 34)

Building your confidence takes a while.

...how's your confidence now?

Er, I'm building it up again, it'll take a while. As I say I only got out of hospital last Tuesday. So, I've not even been out a week yet. So, I'm gonna start building it up again. Which is why I'm not lying in my bed, I'm going up and down the stairs holding onto banisters and things. (P03 starts line 77)

Confidence can grow by setting yourself goals to achieve.

Do you set yourself small goals to achieve and...?

Yes, today I set myself the goal of washing my own hair. Which I could ask my daughter to do, but, or my granddaughter, but I felt it was a goal I should do myself. Cos, I, erm, it meant standing up for a period of time while I washed my hair without really support (...) so that was my goal today. Wednesday it will be a shower. (...) Again, by myself. (.) Because the area that I have damaged doesn't make it easy for me to move about because I have broken my pelvic girdle. So that's bound to make it difficult to move around. (P03 starts line 84)

You shouldn't really take tablets on an empty stomach, so I had to do my hair without painkillers and it did hurt. [daughter mumbles in background] So that was my goal for today and I did it, with that new shampoo... (P03 starts line 120)

Confidence can grow with determination.

...any other thoughts or reflections on confidence ...?

I think you've got to have someone who is determined to get well, if they haven't got that determination no one can give them it. You have got to want to do it and I think the trick is to give them some reason, if they already haven't got a reason, to want to get well. (P03 starts line 94)

3. Guided existential inquiry

Lived body: There is a lot of physicality in this conversation. I recall the participant's front room where the interview took place. She sat in a large arm chair with her walking frame in front of her and a table to the side (where I placed the digital recorder) along with her tablets, drinks, papers and remote controls, all set out and present a physical, and indeed practical position of control. She was small in stature but strong in matriarchal presence. This was reflected in her conversation too. Her physical determination comes through, much stronger than in the text narrative extracted above, to get over the circumstances she's facing with her broken *pelvic girdle* (Line 90). Her pain control is regimented to enable her movement:

I have a patch and I'm about to take two co-codamol. Every four hours I take them. (P03 line 93)

But even *without painkillers* (Line 121), as was the case that morning when washing her hair, she demonstrates her physical coping - *So that's bound to make it difficult to move around* (Line 91). This all connects back to the opening statement from her, describing confidence to mean independence.

Coming back to this connection to independence, she recalls a much older female patient from the hospital. She sees in an envious or maybe jealous way, her lack of frailty:

I mean, there was a woman in the next bed in hospital to me, she was ninety-five. Then she played golf for years, that's bound to help her deal with any frailty. (P03 starts line 68)

Lived space: Her experience of falls is central to her story too. The presence, all the time, of the trip hazards which exist in her environment – *that extra step* (Line 16); *that chair leg* (Line 17); *climbing up and down stairs* (Line 35); *falling over things or falling down stairs* (Line 55); *steps or trip over chair legs* (Line 76). These all collect to undermine her confidence in her lived-space. The worry experienced, from within her internal space, following her falls is connected to words in the conversation such as *judge* [losing confidence in her ability to judge] (Line 15); *watching out for* (Line 16); and *hesitant* (Lines 23 and 31). Overcoming this worry that has eroded her confidence, is her determination.

Lived time: The goal setting improvement plan she has set herself maps out activities to achieve throughout the week. There is a regimented feeling here too, even as she paces out her stair climbing steps for me in the conversation – *going up you use your good leg and coming down you use your bad leg* (Line 37) – her *system* (Line 42). You can feel this happens to an internal beat of time she carries. She is determined to be well for family visiting later in the year, she

has this goal setting mentality to step-by-step regain her strength and confidence that she had lost.

Age is referenced, her coming eightieth birthday – she has tried halting aging (and by earlier association) frailty, by taking vitamin tablets (Line 63), now stopped. Her connection to frailty being age related is something for herself she seems to accept – an inevitability of aging.

Lived self-other: Present with her during in the interview was her daughter, living close by and caring for her when needed. Also mentioned are her extended family and visitors, staying with her later in the year (Line 112 to 115), clearly her family and friends are important to her. She is looking forward to *parties and everything* (Line 114) and this seems motivating to her recovery, giving her independence back and tackling her overall growth in confidence.

During her stair assessment in hospital, the contact with the physiotherapist, they triggered her to address the worry and confidence problems on the stairs. They gave her stair climbing and descending advice, guidance and confidence which she was clearly demonstrating back at home.

Lived-things: As mentioned above, the material things around her, giving her control from her chair at home. The walking aids, giving her control on the stairs. The pain killers giving her control staging her recovery. This control objects are directly connected to her confidence and its improvement.

Participant 04 - Detailed phenomenological analysis

1. Individual interview analysis

Multiple falls lead to you losing your confidence and that feeling you cannot manage as you used to. Losing your confidence means you lose your drive, your *get up and go*.

When you are coming home from hospital your confidence is affected. You think about how poor your mobility is following the fall, being restricted by using a walking frame and being alone, when you get home, affects your confidence. Alcohol dependence has connections to confidence too. For when you are drunk you clearly don't worry about your confidence however, when you are sober and face the consequences of the drink. An example is when sober you realise that the fall you have had creates a new dependency, a physical one. You then realise how on your own you are and that you are not managing at all well; all the things you drink to forget are the things that come back to negatively affect your confidence.

What confidence actually means is hard to put into words and explain. When confident you see yourself getting on well, managing. When you are like this you have a *jump* (Line 165) in confidence, a boost. But falling over a second time, just takes it away. Once it's gone it's hard to get it back.

Unique (incidental) themes: (bold are stronger themes)

Falls takes your confidence away

Coming home from hospital affects your confidence

Losing your confidence, you just feel you can't manage (be bothered)

Being restricted and confined by things out of your control affects your confidence

Alcohol dependency can give and take away confidence

Getting back to normal gives you a confidence boost

2. Meaning and understanding review

Falls takes your confidence away

Having a fall, or having a couple of falls recently, erm, do you think? does that have any effect on your confidence, on your well-being?

Yes, me confidence, yes, I'm not confident, I never got...I don't know... (P04 starts line 66)

Once I had those falls, I lost all my confidence, I just can't seem to manage anymore.

...The fall took your confidence away, but what do you think it did inside you, to affect your confidence?

(.) I don't know (.) I can't explain it. (.) I just lose me ...(.)... I used to get up and go walking... I just don't know, I just don't know. (P04 starts line 76)

...but since I had my second fall it knocked that right down to nothing, right down to zero again. I just haven't got the confidence anymore. (P04 starts line 165)

Coming home from hospital affects your confidence

...I'm not confident, I never got...I don't know...I just don't like the idea of coming to home on my own and on my own and to get my own tea and (.) I just don't feel like it. Sometimes I just don't bother. Which ain't, which ain't no good anyway. (P04 starts line 68)

...first time I come home in an ambulance. The second time I had to get a taxi. Because the taxi bloke was talking to me, it took it off my mind and of course I then got in here and I can't walk, I just couldn't manage to...I had... when I come home the second time I have to...co the first time I came home in an ambulance brought me in, dropped me in and I was feeling alright. The first time it wasn't so bad. It was the second time, the second time, cos I'd been on the bloody booze, I hadn't been home long and I just sat in here on my own, sat in here watching, here you are I'll have another drink and started it all off again. (P04 starts line 102)

Losing your confidence, you just feel you can't manage (be bothered)

Sometimes I just don't bother. Which ain't, which ain't no good anyway. (P04 starts line 70)

Once I had those falls, I lost all my confidence, I just can't seem to manage anymore. (P04 line 76)

...The fall took your confidence away, but what do you think it did inside you, to affect your confidence?

(.) I don't know (.) I can't explain it. (.) I just loose me ...(.)... I used to get up and go walking... I just don't know, I just don't know. I know I could do with some help. That's all I can tell you.

Yer.

I definitely know I could do with some proper help.

So, one of the things you think can help your confidence is somebody coming in to support you with some domestic support?

Yer, doing washing,...

Doing beds?

Doing cleaning, yer, which I can't, I can't ... which soon as I get up and get going about, cor my bloody back, its murder and I have to sit down, I can't do it. I ain't going to bother any more. (P04 starts line 77)

The second time I had to get a taxi. Because the taxi bloke was talking to me, it took it off my mind and of course I then got in here and I can't walk, I just couldn't manage to... (P04 starts line 102)

Being restricted and confined by things out of your control affects your confidence

I can't explain it, at the moment I just don't want to go out. I know I'm going to have to before long. (P04 starts line 144)

I walk about on a walking frame, which I never used to. If I go out I have to use crutches, or so they say, because you can't, you are not supposed to use your walking frame outside. (.) (P04 starts line 63)

You describe you're a little more isolated now, because you are not wanting to go out because of the scar you have got on your head, does that affect you in any other way. Psychologically, how do you...

I don't know actually, no... (.) I can't explain it, at the moment I just don't want to go out. I know I'm going to have to before long.

Sure (...)

I'll have to get back to normal. (P04 starts line 140)

Alcohol dependency can give and takes away confidence

When you had your fall did you think about your confidence, ...?

You don't do you, when you had a few, a few tipples, you ain't, you not worried about it. It's only when afterwards when you, you realise that you ain't got no more confidence in yourself. (P04 starts line 91)

Getting back to normal gives you a confidence boost

Can't put it into words, I can't tell you why or nothing. First time I, once I got home I got going back to normal again, sort of nearly back to normal, my confidence I suppose jumped up a bit, but since I had my second fall it knocked that right down to nothing, right down to zero again. I just haven't got the confidence anymore. (P04 starts line 163)

3. Guided existential inquiry

Lived body: The falls affecting this participant's confidence have affected his physical body. His back-pain limits his daily living tasks and his poor mobility, he is restricted to using a frame. This is clearly an experienced burden and frustration that's impacts on his functional ability. This new disability and lived-body limitation is connected to his dependency and repeated calls for help and support in the conversation: *doing my breakfast, making my bed, and I struggle round too, so my cleaning...* (Line 62). The visible sign of his fall, a very noticeable wound and scar on his forehead affects his confidence and further limits his independence, restricting him to his flat:

Looking at that [forehead scar] and I can't go anywhere now, and they see that on there, I'm going to get people saying, 'what's happened to you then'..., you been on the booze haven't you'.

...

They will say you've been drinking?

...mates, they say 'I'll bet you've been on the booze'.

Right.

I don't feel like going out at the moment, till it wears itself off...I don't know how long that's going to be. (P04 starts line 126)

Lived space: Confined to his flat, his confidence is confined too. The lack of confidence he experiences is restricting his ability to go out and socialise, worried what others with think. In part of the conversation he gesturers to the floor in front of him (post interview reflective notes) re-living the moment he fell and lay on the floor in his flat, unable to get up. He connects this to his friend's comment telling him, that if he didn't stop drinking *someone will come in here and find you dead on the carpet* (Line 38). Later internalising the message, telling me *...and they'll find me on the floor DEAD!* (Starting line 48). The frustration of the fall clearly shows through as well as the consequences on his confidence.

Lived time: Confidence related to lived-time is reflected in his experience of a prompt recovery following his first fall, but the *second time* he fell, mentioned four times in the paragraph about coming home (Starting on line 102, referenced above), left him dependent, struggling to manage, frustrated with his situation and lacking in confidence. His drive to functionally recover and get *back to normal* is mentioned four times too in the conversation (Lines 147, 148, 164 (twice)). The time it is taking to return to a previous level of function is

connected to his confidence experiences: in line 165 he recalls it *jumping* on return to normal following his first fall and his confidence experiencing a great knock following his second fall, *right down to zero again* (Line 166). A confidence against time line graph would show it as a series of peaks and troughs.

Lived self-other: He sees getting out of his flat and reconnecting to his *mates* (Lines 40 and 112) and as a motivation and connection to his confidence. His isolation affected is confidence, an isolation brought on by his body-image concerns (described in the lived-body section above) and current levels of dependency. His dependency falls beyond his physical and to a social level as he looks to others to help meet his domestic support needs, as the interview was around a planned social worker to visit as he sought help to manage again, to respond to his *struggle* (Line 62) and within this managing his confidence.

Lived things: The idea of managing and the connection to confidence comes over again in the brief conversation about mobility aids, these lived-things and, for him, the help and burden they bring.

I walk about on a walking frame, which I never used to. If I go out I have to use crutches, or so they say because you can't, you are not supposed to use your walking frame outside. (P04 starts line 63)

This technology-thing is practical and easy to understand the idea of managing is much more complex a thing.

Manage means: *Succeed in surviving or in achieving something despite difficult circumstances; cope* (Oxford University Press, 2018). Managing's connection to confidence comes in what I believe was unsaid, here is the sentence about coming home from hospital:

...I can't walk, I just couldn't manage to... I had... when I come home the second time... (P04 starts line 104)

I believe the unspoken connection was: *...I just couldn't manage to... I had [no confidence] when I come home...* . The inability for him to see how he could succeed, how he could achieve his ambitions, how he could cope eroded his confidence this second fall. Managing as a lived-thing and existential-thing is woven throughout his narrative.

A further technological-thing he connected to his confidence was a pendent alarm. Not captured in the conversation, but afterwards.

Participant 11 - Detailed phenomenological analysis

1. Individual interview analysis

Communication has a central role to play in how your confidence is experienced and lived. In exploring frailty, even when your confidence is good, it exists in a delicate and fragile state. However, this balance can easily tip by being let down by poor communication. In these cases your confidence lowers, you can become easily intimidated and unable to defend yourself. You become more vulnerable and fragile. Poor communication can cause a mental torment that connects to your confidence and erodes it away. This personal, internal weakness is hard to admit to. Frailty feels like: not being able to defend yourself, it makes you angry and this anger leads to frustration and disappointment. This frailty and lack of confidence is like being out-of-control, a helplessness, it can open you up to abuse. It comes on and goes slowly, it also has an accumulative effect and links to other factors, like physical weakness and loneliness. Fear however, overrides all of this and has a destructive affect to your confidence. You need to fight fear to overcome low confidence. You must fight to say what you want to say. If you cannot defend yourself, you cannot have confidence.

Coming into hospital is a most frightening time, it is always linked to losing your confidence. In hospital you struggled to communicate, to be understood, to be listened to. Sometime when in hospital you are not in the right state of mind – delirium – it's like a mental stroke – you have strong, uncontrolled raw emotions, it feels like you are out-of-control, it is horrific. You might be in tremendous pain, but not able to get through to those around you – you lose confidence in them and the situation you are in. Or you may have a raging temperature, you feel frightened and unable to communicate effectively, wanting to cool down by fighting your clothes off. You cannot make yourself understood, you quickly lose confidence in the whole system.

It is not just this mental torment where poor communication affects your confidence, living with physical weakness affects it too. Often people misinterpret your actual needs, and this leads to confidence loss. Because of this physical dependence on others you may need to live in a care home. Experiencing, even temporarily, a care home can have a devastating effect on your confidence. You may witness and be subject to the most de-personalising experience through social isolation and the lack of mental and physical stimulation you can imagine. Good communication is confidence giving, but it is rare to truly find.

Living your life with a long-term mental health problem, with depression, is another example of where you can lose your confidence. It is one where communication with health professionals becomes important, but often through

poor communication, trust and confidence are significantly affected and this in turn can have a detrimental effect on your health status and well-being.

Unique (incidental) themes: (bold are stronger themes)

Confidence goes when communication is not effective

Confidence is connected to fear

Confidence is lost when not in control of yourself or the situation you are in – a helplessness

Depression can take your confidence away

Confidence is linked to social isolation

2. Meaning and understanding review

Confidence goes when communication is not effective

How would you describe confidence?

... the confidence to do what you want to do, the confidence to say what you want to say. (P11 starts line 18)

Can you recall a time when you have lost your confidence?

Yes, several times. Erm, but that was because nobody was taking notice of what I was trying to say, and I was not able to get over to them what I meant. Erm, that's where I lost confidence, erm, because not being able to, erm, communicate is bad. That's when I lost my confidence then. (P11 starts line 22)

Yes, I don't mind what I share. Erm, this was in another ward, up higher I think, I was trying to, (.) I was laying on the window sill. You know they have got very wide window sills and I was laying on the window sill trying to get comfortable and I couldn't, because I think I had some sort of a mental stroke or something that was affecting the ways I was looking at things and I was laying on the window sill crying out in pain and I said to the nurses, please get a nurse or doctor and all they wanted to do was take my blood pressure and they took it fifteen to twenty times, erm and left me in pain on this window sill and I lost a lot of confidence then because I could not get through to them that I was in pain and I needed pain medication and all they were doing was chatting, not laughing exactly, but they weren't being very serious about the fact I was in pain

and needed medication. Well I lost a lot of confidence then because I could not get through to them. (P11 starts line 32)

Confidence is connected to fear

But, the fear in that is terrible because you can't do anything to get through. (P11 starts line 166)

Fear is something different, something awful erm, its much worse than frailty and erm, I can't say anything more as I haven't experienced anything more er... (P11 starts line 179)

[Tape stopped and later restarted as the participant talks some more about frailty and fear]

...it just means you are feeling frail. But fear is a real stopper. (P11 starts line 229)

Yes, if you can do that you got to acknowledge you can fight the fear because without that confidence to fight the fear you won't fight it. That what I feel, why can't everyone feel confident, why do they have to become frail and er, vulnerable erm, and that's life isn't it. (P11 starts line 233)

Confidence is lost when not in control of yourself or the situation you are in – a helplessness

I thought what they were doing was absolutely useless because, I'm not a medical person but I have a good idea about how the body works, and I've been in hospital enough to know, you know this from that, and they were doing absolutely nothing at all to alleviate my pain or to sort out what the problem was. So, I lost confidence in them. I very rarely lose confidence in myself. (P11 starts line 46)

Erm, (...)(...) Again, it wasn't so much losing confidence in myself, but in the situation around me and the conditions. The fact that they had removed half of my (...) what do you call it medication, er? What's the word I want, I keep getting stuck for words?

Your antidepressants?

Antidepressant, that took away half my antidepressant, that didn't tell me and it takes about four weeks to run down and another four weeks for it to build up. Erm, When I was down...

[interrupted]

...the thing is no one told me, so when I started to get depressed I wondered why because I hadn't been depressed for quite a long time. (P11 starts line 61)

...no one told me about taking the antidepressants off, so when I started to get depressed I wondered why and of course what something like that happens you blame yourself, it's a natural reaction. You think has something gone wrong with me instead something gone wrong with the system. (P11 starts line 74)

But I think I am over my renal problems now, so hopefully they will put them back on. And I'll go back up again. But, again, that was a time when I lost confidence because the system was not letting me know what was happening and I was assuming it was my fault and not somebody else's fault which isn't very often, because you know I can speak up for myself. Erm, there are times when I wonder what's going on, whether it's me or the system and generally, it's the system [laughs] [coughs]. (P11 starts line 79)

if I lose my confidence it is sometimes I think it's something wrong with me rather than the system. (P11 starts line 93)

Sometimes you ask a nurse, can I do this and they misinterpret because they jump to conclusions and they'll do something you don't want them to do, but they want to do, which is fair enough, erm, then I lose confidence. I cannot get across to them what I really want... and they have already gone off to do somebody else, so that can lose confidence in an old person. (P11 starts line 128)

when I felt so weak that I couldn't ask for anything erm, that was very trying, erm, again you feel helpless, because there is nothing you can do to get through. There was a time when I wanted to take all my clothes off and to sit in front of an electric fan and I kept trying to do this and of course they kept trying to put my clothes back on, I kept pulling them off again and I wanted to sit in front of the fan and with it full on cold. And I was hot, I was hot all of the time and all I wanted to do was to cool down and I couldn't get anyone to understand that's what I wanted and it got quite stropky in the end with me pulling my

clothes off and them putting them back [laughs] again because that was the only thing I could do because I couldn't communicate, I had no words to communicate with, er, that's all I could do with a physical thing, to keep doing it and er, in the end the same thing happened with bed clothes. I wanted to throw them all off and they wanted to put them back on and we came to quite a few tussles before they realised because my actual temperature wasn't high, it was, I don't know why it was high, so, it didn't record as high for some reason. Erm, and I just felt hot all the time and once I could get that coolness I was allowed to take my clothes off and sit in front of this fan I was as good as gold because I was communicated in some way to what I wanted and that was something. But, the fear in that is terrible because you can't do anything to get through. You lay there hour after hour, you think, what are you going to do, how are you going to communicate, how are you going to get through to them you're in agony. You need to take these things on. Erm, yes they were hard times, yes frightening times, erm, and I often wonder when they are laying in their beds and someone comes along and covers them up and they want to be uncovered because they are too hot and someone comes along and puts a blanket over them. I think, oh, how awful, what on earth are they going to do if they can't say they want that off. (P11 starts line 149)

I think when I went to a care home and they said I would enjoy that, all the people to talk to and all that and when I got there, there was just a line of people staring straight at the telly. And I thought to myself, is this what society is about, is this, you know, is this all there is left erm, and yes, yes, my confidence in that went right down again, because I was expecting something a lot different and all I got was (.), it looked like death plastered on the walls erm, and I thought that was all I had left as well so of course my confidence went down with it. Erm, I have come back here, so I don't know what they are going to do with me next. (P11 starts line 186)

We are not all idiots, we are not all stupid and we are not all ignorant erm, some of us are, some of us aren't, some of us could be if they were allowed to be, some of them could be different if they were erm, extended a bit erm, (...) (P11 starts line 208)

Yes, that's usually what happens, or I assert myself to such an extent that I get something happening erm, but that takes a lot of doing when you are not feeling very brilliant, to force yourself to erm, do something like that (.) (P11 starts line 211)

Depression can take your confidence away

Confidence? to do with mood?...or your mental well-being? How do you recognise you have lost your confidence?

I start thinking about negative things instead of feeling buoyant and positive, erm, things start looking very grey and then become black and then I become very depressed. (P11 starts line 117)

Confidence is linked to social isolation

I went to a care home and they said I would enjoy that, all the people to talk to and all that and when I got there, there was just a line of people staring straight at the telly. And I thought to myself, is this what society is about, is this, you know, is this all there is left erm, and yes, yes, my confidence in that went right down again, because I was expecting something a lot different and all I got was (.), it looked like death plastered on the walls erm, and I thought that was all I had left as well so of course my confidence went down with it. (P11 starts line 186)

I don't think I could have stood it there much longer it was just like looking at death all the time. (P11 starts line 198)

I didn't contact them because they weren't, they weren't the people I wanted to talk to.

No?

They weren't lively, they weren't erm, attentive they just stared blankly. I didn't want that, I didn't want to communicate with that erm, so (...) I can't think what it was like, I have tried to wipe it out of my head. Erm, (.) but there were different layers of people who are bedridden. (P11 starts line 202)

3. Guided existential inquiry

Lived body: There is a physical-ness within the interview with this participant and a palpable wrestling with a survival instinct that is physically fighting against the system. Her context of confidence is captured as she grapples with her perspective at the end of the conversation - *without that confidence to fight the fear you won't fight it* (P11 line 234).

Fighting is visible in her descriptions of delirium (Starts line 149, see above), she clearly knows how her body works and exhibits a physical frustration in how medical staff are unable to control her pain or temperature.

Lived space: The presence of depression in her inner-space is all too clear in her lived-experience account she gives in this conversation. She describes her mood - the greyness of it, changing to blackness. Connecting to her outer-lived space and its connections to confidence. Here she is graphic in her description of her delirium, the laying on her window sill to get comfortable, the fighting with clothing and electric fans in her room to cool down. The hospital environment was confidence eroding for her. It fought against her too.

Lived time: Time becomes relevant in her experience of depressions: the poor communications over medication dosing, causing her depression to return is linked to her understanding that the anti-depressant medication and how it takes time to leave your body and to build-up when restarted. Time becomes important to her again as she describes her lived experience of being in the care home, a haunting experience in many ways, the month she stayed before being readmitted and one she shares she has tried to wipe from her mind. Both of these she expresses in the context of confidence.

Lived self-other: Physical and verbal relations, as described above, appear throughout the conversation, normally in conflict. There is a tension between the medical professionals, the doctors and nurses around her. She is clear her depression was medically induced (Line 57) and the nurses are only here for a good time, not to provide compassionate care (Lines 15-16). For the health professionals to un-see her pain resulted in confidence loss (Lines 39-43). However, she is clear this is not a personal confidence loss, but a loss of confidence in them. A breakdown of trust.

Lived things: It is sometimes the immaterial lived-thing that generates the impact in a conversation. Here, the two delirious lived-experience accounts the participant gives are powerful, it feels that in talking about them, she is still trying to understand them. Listening to the recording of the interview you pick up a sense that this is the first time she is telling someone of these experiences, so although pulled into conscious thought, there seems little reflective resolve as they are shared. The stream of experience she describes, about wrestling and tussling of clothing in the second account particularly (Lines 155-161) and how communications failed to connect and flow more freely. Here she describes her experience of helplessness in connection to a question asking for a time when she had lost her confidence. The descriptions reflect no sense of control, in many ways the description depicts an account of the situations being out of control. The physical wrestling and tussling mirrors that of how communication is so often un-connecting, between herself and the health professionals and how

she sees it between her and society and the system. There seems to be a personal fight she wants to take on with authority.

Participant 13 - Detailed phenomenological analysis

1. Individual interview analysis

Falling and having multiple falls 'knocks' your confidence. It causes you to worry about falling. The fear of falling is constantly on your mind, when walking or carrying out other daily living tasks, such as showering, this continuous fear affects your confidence. The way people talk to you, about your fall, can affect it too. Negatively, people can cause you more worry, telling you to *be careful, not to do this* or *not to do that*. These curtailments cause an apprehension that strips away your independence and this influences your confidence too. This may lead to isolating yourself from others and this has further consequences (described below). However, having the right walking aid with you, to overcome the fear of falling, can help your confidence.

The other thing that 'knocks' your confidence is when those caring for you have the wrong attitude. They can be quick, strict, demanding and sometimes unkind. This attitude erodes your confidence – having someone caring for you overnight for example, someone that is sharp or short with you, makes you fearful to ask for help.

Exploring confidence through the life-course – confidence is something that is seen necessary to have and hold onto, to 'take you through' that life-course. However, as you get older, it is harder to keep hold of. As you get older, life seems to speed-up and keeping hold of your confidence becomes more important, but your general state of mental well-being needs to be strong to do this. There are two types of people with describable confidences. There are those born with it, they have good confidence 'from birth' and it takes them through life's course. The others are those who struggle with it from an early age, at school, exam performance for example, they may be stifled by silly mistakes or nerves. This can have lasting and repeated consequences throughout life, with driving as another example, where nervousness can affect confidence and performance.

Getting old is frightening and becoming dependent on other people looking after you is too. Looking around at others in hospitals, you see their vulnerability, these older people are frightened and are lacking confidence, even to call for help. This is a fear you can see in yourself as you lose confidence, this is often

associated with being in hospital and especially when not spoken to well. An abrupt doctor can affect your confidence, the same as that uncaring nurse you may have on night duty. At the end of your aged-life, the chance you need to go into care may arise. You hear stories and may experience life-long friends doing this and then may hear of the detrimental consequences this experience has on their confidence. It makes you fearful. You recall one such lifelong friend absolutely hating the idea, but recognised the necessity. However, the lack of stimulation, engagement and motivation (complete isolation) stripped away any confidence they may have. They disengage with everyone and withdraw. This plays on your mind as you become more dependent. You see confidence is ubiquitously with us (or not), virtually from cradle to grave.

Social isolation can be a self-imposed consequence of a sequence of falls, to protect yourself. You think you are not safe to go out and this leads to loneliness. You feel you are becoming a burden and you lock yourself away. You stop friends visiting, but with decreasing family contact too, isolation comes quickly. The knock-on consequence is that you start losing your confidence. The cycle of loneliness can be interrupted by visitors or by getting out of the house, you realise, maybe too late how this can dramatically boost your confidence again. This often must be organised for you when the downward cycle of loneliness is set in, and when you may not be able to see it happening.

When anxiety hits you, you become paralysed to help yourself. It is only through medication and the input of the community mental health team that the confidence lost (that results in not going out for a walk with your dog for example; not going shopping; not connecting to people generally or; not looking after your overall mental and physical well-being) can be helped. Recognising barriers to confidence loss are important. In these circumstances keeping a diary and identifying triggers for your anxiety can be worked through. Meditation and facilitated group support meetings help. Taking small incremental steps aid recovery, your re-engagement back with society and re-gaining your confidence again.

Unique (incidental) themes: (bold are stronger themes)

Being fearful of falling knocks your confidence

Low confidence causes you to be frightened to call for help

Your walking aid gives you confidence

The attitudes of others negatively affect your confidence

Confidence has a life-course connection

Social isolation and loneliness are linked to confidence loss

Anxiety and stress have a direct impact on confidence

Treating anxiety (with specialist interventions) boosts confidence

2. Meaning and understanding review

Being fearful of falling knocks your confidence

Like in my case, I've had several horrendous falls, you know, to make occasion or whatever but, I have a dog and I go walking but I find that my confidence has been knocked by these falls, so when I'm walking I always keep my elbow crutch with me, erm, but, it takes your confidence as though, your sort of walking along and I'm thinking 'I mustn't fall, I mustn't fall down' or anything like that. So, sometimes when things like that happen you can say that knocks your confidence. (P13 Starts line 7)

I went for a shower, ... I went in there and, they got all the rail in there for you, and I was so nervous, you know, because all I kept thinking was 'On my god, I mustn't fall, I'll be kept in longer, I mustn't fall' erm, I think that goes eventually... (P13 starts line 30)

Low confidence causes you to be frightened to call for help

I look and watch what's happening and it really is amazing, because some come and they have, you know, 'Come on my sweetheart' and (.) they may need the toilet again after that. And if their confidence is gone they are frightened to ring the buzzer. (P13 starts line 54)

Your walking aid gives you confidence

Well confidence means to me, erm, having first of all the equipment that is available, you know, so you have got it there, rather than struggle. Like in my case, I've had several horrendous falls, you know, to make occasion or whatever but, I have a dog and I go walking but I find that my confidence has been knocked by these falls, so when I'm walking I always keep my elbow crutch with me. (P13 starts line 6)

The attitudes of others negatively affect your confidence

Another thing is, well what knocks my confidence, is if you come into hospital, erm, some of the staff, and this is applicable to anything really, are really lovely and that makes such a big difference to your confidence. Like, for instance, like when night-time comes you look and see what nurses are on you see. And

then, there may be one where I think 'Oh my goodness, she's on tonight', she might be a bit quicker, you know, a bit stricter when getting the thing. But, when asking for something, and they say 'Yes, I'll get it for you, I'll won't be two ticks', you know, you don't mind asking them again because you know they are going to be alright. (P13 starts line 13)

Attitude [of others] plays a big part in your confidence I think. (P13 line 25)

So how do you change? how do you feel that change? ...

Well, you just relax much more and just look for them and hope they are going to be on and it's a job, particularly if you are on your own, er, and something happens to regain your confidence, erm, if you take the other night. I went for a shower, ... 'Cos, if a person has good confidence, i'll, 'I'm going to go in, do my best, I'm going to do it, if it comes out right is ok, if it comes out wrong then.' I would get in a state about going to do that. Then, what I could actually do is lost, because I make silly mistakes because I am so nervous. (P13 starts line 26)

I think confidence, kindness and attitude towards people are the three biggest thing that can make an elder person life a life happier. (P13 starts line 41)

I think that. Some people think they've got lots of confidence, it may not bother them, you know (.) but I think as everyone gets older they need that sort of thing, er (.) to be looked after and it's the attitude, particularly in hospitals and doctors. You know, if a doctor comes off very abrupt, your immediate confidence, well mine anyway, has gone, so then I'm all twittery and I forget what I'm going to ask him. But if he's a doctor, that's, 'Come on, sit down, tell me what your problem is', you know, different again. That's how I can only describe confidence. (P13 starts line 45)

I think it's [confidence] different in certain people, but particularly when they are old and vulnerable and they can't get up when they want to, you know, that, I mean, I've been here a week and I've because I'm not actually been ill, I look and watch what's happening and it really is amazing, because some come and they have, you know, come on my sweetheart and (.) they may need the toilet again after that. And if their confidence is gone they are frightened to ring the buzzer. That sort of thing. (P13 starts line 51)

...attitude of people looking after you and particularly as you get older and you can't do these things. Its, (.) I find it rather frightening really, I do yer. (P13 starts line 74)

...as you get older it gets harder, you know, harder to, I won't say understand, but to find, erm, people that will give you your confidence. Because they live such a fast life today and at hospitals, they are particularly so pushed aren't they, and you know, we all get irritable at time, but it does. In those terms, like many people, going to see the doctor, you know, you 'I'm going to see doctor so-and-so, because you can talk to him, he'll sit and listen' you know another doctor might say, 'What is it, oh yer that'll be alright' and the person goes out and, and they don't really feel like they've got any confidence in the person, in the doctor. (P13 starts line 105)

Well, I think it's very important that you try and keep your confidence, because (.) particularly if you've, say been in hospital and your visitors come and they say, when you come home you are not going to do this and you are going to get rid of that and. I don't like that, I want to go home and look and see, you know, why I fell and, by not concentrating on what I was doing and pick up my life as it was. I don't want to alter everything because I'm older and I had a fall, or several falls. (P13 starts line 231)

I don't like people saying, (.) I take advice but I think if you say I, erm, listen to somebody 'Oh I don't really want to do that, but I'd better go along with that ', so I think you have got to have the confidence to say, 'No, thank you very much but this is what I want to do, not that' and just leave me so I can, you know. It's no good someone saying to you, if you fall and they say, 'Were you going out with the dog – Oh, you want to be careful, what happens if you fall?', well that knocks your confidence right down. You have got to be quite strong to say, ignore that. And that's the wrong thing people should say. They could say, 'Be careful, don't fall', but not, 'I wouldn't do that you know, what happened last time?', you know, so (.) That's it. (P13 starts line 237)

Confidence has a life-course connection

...all I kept thinking was 'On my god, I mustn't fall, I'll be kept in longer, I mustn't fall' erm, I think that goes eventually but, confidence, you can take it back to school days – exams, that sort of things. 'Cos, if a person has good confidence, I'll, 'I'm going to go in, do my best, I'm going to do it, if it comes out right is ok, ... (P13 starts line 33)

I think confidence takes you through life really, whether you have got it or whether you haven't, erm, its takes you through your life and as you get older it get harder, you know, harder ... (P1, starts line 104)

Confidence, ... I think is something that is with you when you are born. You either have good confidence and that takes you through life or you have poor confidence, in which case you struggle, and you do. It's a big thing. (P13 starts line 161)

I don't think anybody goes through life without confidence at all because I don't see how they can go on. (P13 starts line 215)

Social isolation and loneliness are linked to confidence loss

Can you think back and try to describe how confidence was, ... You've had a fall and you've lost it, what does that feel like or...?

I think that's the start of somebody becoming isolated, you know, because they don't have the confidence to do these things. They stay in and think, well, I'll not go out in case this or that happens. So, you could, through a lack of confidence, become very lonely. You could be sitting in your house feeling relay miserable, you know, you haven't got the confidence and then somebody might come in and say 'Arh, come on, I'll come with you, we'll go down so-and-so, you'll be alright', you know, unless you are really bad, you would say I'm not going to, if you got the chance you would go. I think that's BOOSTS your confidence again, you see. So, in a way, you start off again. But, its whether you get that, because as you get older you haven't got the mobility to get out and speak to people, yet you have got to wait for them to come to you really, particularly if you are on your own.

Is that a little bit how your situation is, because I don't know much about...

Yer, I'm single and I have no family, well I have a brother and sister, my brother who died who lived up in [West Midlands Town]. They have a daughter, my niece, who is severely handicapped. I (.) go and see them occasionally when my neighbour takes me cos, well, I've lost my confidence to drive to [West Midlands Town]. (P13 starts line 80)

I think like, if they make these things, erm, what do you call them, happy hour sort of things where elderly people go, and they play a game of bingo and so,

But to them, you know, they think that's really lovely and it gets them out. There again, it boosts their confidence,

I think you are right, and what sort of things happen then when you're with other people that makes your confidence grow?

Well, you feel happy you feel good you want to do more, so you know, really, you feel that you want to start, erm, your confidence growing again. (P13 starts line 120)

...in a way you feel wanted again, not just been put on the rubbish heap because you are over 70 or something, or can't walk properly and there is always something, an elderly person unless they were severely handicapped could do, erm, I have seen it, I have a friend who was 92 and I know her for 50 years and she has recently died and she was fine, but she had to go into a home because that was the only safe way and she hated it, you know, she lost all her confidence you know. She was a business person and she absolutely had no confidence at all... (P13 starts line 130)

How did you recognise that confidence had gone in her? What was different?

... Their inclined to just sit, there's nothing to motivate them. So, really all their confidence goes and to me they become a sort of cabbage because they have nothing to interest them. They just look at the clock for meal time and then they are put to bed at seven o'clock. (P13 starts line 137)

...if you have a low, sort of, well if I say, mentality or you're a nervous person anyway, erm, then you are inclined to get into your home and sort of hide away, 'I don't want to see anybody' or you know 'I can just stay her on my own' and become a sort of recluse. (P13 starts line 151)

Anxiety and stress have a direct impact on confidence

Back in 2001, I've always been a very jolly happy person, you know, having a good sense of humour and in 2001 I went to be one night, woke up the next morning and thought, 'God, I feel awful' and it wasn't what you call a mental breakdown they called it anxiety and stress and for, if it hadn't been for the mental people, which there again they come, bit by bit give your confidence back, erm, that happened to me and that was dreadful, I'm still on medication for that, but I don't care what I take as long as it keeps them away, I've had a couple of hic-ups along the way, but... (P13 starts line 167)

Anxiety on its own (.), but unless you've had it, people wouldn't understand, you know, they would say, 'Pull yourself together'. Well you wouldn't be in that position if you could, so I think that's far worse than the anxiety you would have if you fell down the steps like I did, but you know, I got up and moved around again it goes a lot quicker, that one, but not the anxiety / mental one. (P13 starts line 201)

Treating anxiety (with specialist interventions) boosts confidence

What sort of things did they [specialist mental health team] do then?

Well I had to write every day (.) and then they read and with a red pen I've put so-and-so and put but I felt very anxious and there was reams of it because this went on for some time. Well, then, as we got, like a bit stronger because I got, I wouldn't go and shop you see, I would go down say [Name of supermarket] in a car, and I would sit in the car and I would say 'I can't go in there, I can't do it'. So, I would go back home, do then my next achievement with the mental health team was. You've got to go in, even if you just poke your head in the door, you know, that one step nearer and that's gaining you a little bit more confidence and that's how it went once and I can remember one time I done it, I put this stuff in the trolley and there were several people at the checkout and you can feel it coming over you, you know, it's very hard to describe, erm, and I thought 'I can't stay here, I can't stay here', and I just left the trolley and went out and got back in the car. All things like that, minute steps all the way, you can't, there is no way you can do that in five minutes. 'Cos that took about two years and I consider myself very lucky that I had them, erm, to help as they did, you know, 'cos some people say that 'oh, no God, no' but they know what you are dealing with they know how I had to go about it. All the time they are trying to give you your confidence back aren't they, you know, yer. (P13 starts line 177)

I went to everything they threw at me, erm, meetings where you sit and like meditate, which I always thought were a load of rubbish you know but it all fits in when you that areas of er, sickness or whatever you like to call it and er, yes, they took you to meetings and then you would have to perhaps have a conversation with a gentleman over there or lady over there. Well at first you would splitter and splutter, you know, and bit by bit you became more confident and so you could sit and have a sensible conversation and er, that's where the confidence is. (P13 starts line 209)

3. Guided existential inquiry

Lived body: The physicality of walking and the independence associated with this need to walk – the internal talking to herself, ‘I mustn’t fall’ (Line 11), comes through as a significant element affecting this participant’s confidence in the interview. The negatively described view of not being able to walk well enough, is interpreted as being seen by other as only being good enough for the ‘rubbish heap’ (Line 130). Walking is important, and walking with her dog is an important connection, especially as loneliness is explored in the conversation with reference to confidence too.

Lived space: The participant thought others perceived her to be confident (Line 45) but denies that to be the case with examples about the attitudes of others and two years living with anxiety eroded it. Despite this, her inner-space, her emotional bearing and connection to confidence was present throughout the conversation, she had a determination for independence, despite a level of dependency and a resilience.

Lived time: This participant recognises confidence throughout the life-cause. From birth to the description of her friend of fifty years, in a care home at the end of her life. A life stripped of confidence at the very end, which saddened her, but may have also tolled the future chimes for herself in some way. As, in the conversation she mentions older people living longer and the local growth in the retiring population and the lack of facilities for them, which I took to mean care homes (Starting line 114). In hospital she recognises the healthcare staff are busy, she notes that ‘...*they live such a fast life today*’ (Line 107) linking this to their irritability and theme of poor attitude of others eroding her confidence.

Lived self-other: This participant is single and has no family (Line 94). Her close friend, in the care home at the end of life is a significant other. She refers to her, being no more than ‘*a cabbage*’ (Line 142) and who is confidence-less, due to the lack of stimulation. This becomes significant to her narrative. Her loneliness comes over as a significant issue for her too, the episode of severe anxiety took her away from human contact, she describes a solution she would have loved to have seen and maybe she saw herself as Mrs Jones [the participant’s made up name]:

...if there was someone going round to these people ‘Mrs Jones, she lives at number 22 and there is Mr Smith at number 36, let’s see if we can start to’, you know, a little afternoon together for them and give them an interest. (P13 starts line 154)

She describes herself as a *jolly person* (Line 167) with a *good sense of humour* (Line 168), a personality it feels dependent on human company to thrive. In the conversations she talks openly about the mental health team assisting her

recovery and the initial discomfort of meeting people in group treatment sessions:

...they took you to meetings and then you would have to perhaps have a conversation with a gentleman over there or lady over there. Well at first you would splitter and splutter, you know, and bit by bit you became more confident and so you could sit and have a sensible conversation and er, that's where the confidence is, ... (P13 starts line 211)

Lived things: From the very start of the conversation confidence is connected to having the right equipment around her to function. These experienced lived-things are confidence giving. Her elbow crutches are key to helping her control that continuous argument in her head, 'you are safe, you are confident walking – you are going to fall your confidence is going'.

Participant 18 - Detailed phenomenological analysis

This is an unusual analysis. The epoché-reduction section of the analysis is added in for contextual analysis reference (Section 4) It is recommended that Section 4 below is read before starting here, at Section 1. The analysis of this very short interview, which on face value was not felt to expose any lived-experience, has been reviewed in light of what emerged when the post-interview reflective notes were analysed. This interpretive analysis presents a nearly-told perspective of lived-confidence.

1. Individual interview analysis

Confidence needs to be built up before you go home following a long hospital stay. To get back up on your feet after you have lost your strength (after being deconditioned) in hospital, you need to be determined.

There is a degree of acceptance, as you get older, you cannot do the things you used to, and you have not got the things around you, you used to have (loss). There is now a growing dependency on others, and this affects your confidence.

Unique (incidental) themes: (bold are stronger themes)

Confidence is connected to your physical strength

Lived-loss and confidence are connected (see section 4 below)

2. Meaning and understanding review

Confidence is connected to your physical strength

Can you tell me a little bit about your confidence and how it's been affected these last few weeks or so?

You've got to build it up again [...] that's it.

That's it? So, what...

...and I think I can, when I get home.

What's affected your confidence recently? What's caused your confidence to go?

Nothing's affected it. These things seem to spring up on you. You're lying in bed for a week and you lose your strength. See, That's the trouble. (P18 starts line 3)

I've not lost my confidence as such. No, it's just frustration more than anything.

So, you've been in bed for a week and you have lost your strength?

And it creeps up on you. It should be explained to people. You have got to have a transfusion and you got to lie down, as simple as that. (P18 starts line 19)

What enabled you, what helped you get up on your feet?

Determination I would say. You have got to be determined to do it.

Good, and your mobility now, how are you getting on?

Well I think, with a bit of practice... (P18 starts line 25)

Lived-loss and confidence are connected (see section 4 below)

...how long has your health been not as good?

Well I've been very lucky. I was in fishing by myself until gone my eighties.

What sort of fishing did you do?

Mackerel catching, I had a few falls in the harbour, and I thought it was time to pack up [laughs] and there is never any help when you fall in. It's funny that. (P18 starts line 37)

You fell in the harbour?

Yes, so I thought it was time to pack up then.

Oh dear, frightening?

Well not really you know. Part of the experience of fishing.

So, you packed fishing up a little while ago?

I had to sell the boat, it's at [South-West harbour] now. I rebuilt her after father died. She is still going.

Good, so what happen after that health wise?

I just used to go down the town, down the mission. We used to go down and have a cup of tea or coffee. Until they closed it. It always comes down to money. I sold the boat and that was it. (P18 starts line 44)

...since you gave up your boat, has your confidence been knocked?

No, you have just got to change down. You have a big step to make. Accept the case. You can't do it and that's it.

How do you mentally prepare to pick yourself up and get going again?

It's being pretty strong I guess. I good that way. Father was a fisherman and one thing and another. Yer. So, there you are. [interview ended] (P18 starts line 60)

3. Guided existential inquiry

Lived body: A physical strength loss connects lightly to this participant's confidence loss. Much more in the untold narrative than in one exposed in the conversation. The theme of loss is pertinent to his fisherman's tale.

Lived space: A this participant reflects on physical strength, he references mental strength (Line 65), a strength he saw in his father too. His lived-space has narrowed, from the vast ocean, harvesting its mackerel whilst battling with the elements the seas and weather can bestow. To his home, with his wife and its specialist equipment - *Raising chair, stair-lift, a rising bed*, (Line 31) that maintains the physical ability and strength he so wants to retain.

Lived time: *Well I've been very lucky. I was in fishing by myself until gone my eighties* (Line 38). This lived-time is now lost. His narrative is clear about how time has taken away his physical ability, predominantly his mobility (it's interesting he does not mention his vision in the conversation too). His father's

death, the time he put into renovating his boat, to the point his harbourside falls led his to selling. And in that time, he lost further his health and confidence.

Lived self-other: a practical fisherman who fished well into his *eighties* (line 38), this participant was independent and being pragmatic all his life it shows in how he relates to his wife. After talking about the loss of his boat and his father, he matter of fact states: *my wife, she is still living. She is 88* (Line 56). It was not a long interview and he wanted it that way. Therefore, opening up to know more about his lived-relationships was challenged.

Lived things: Practical at home as he was as a practical as fisherman all his life – he factually connects to the practical things around him. At home:

I have a small house and it's more convenient. I have got all of the conveniences as well. Raising chair, stair-lift, a rising bed, (P18 starts line 30)

However, the lived thing present in his short narrative was his world, his lived-experience of a fisherman. This fisherman's world is a thing of things, outside the world unaware, but inside, maybe the family, but with other fishermen, and in the Mission, the world of knowing, not exposed here, dwells – a brotherhood. The loss of this world feels connected to a confidence loss just touched on here, here in this conversation.

4. Exploring the epoché and conducting the reduction

It is very difficult to see of any lived-experience of confidence come from this interview. The participant denies losing confidence:

I've not lost my confidence as such. No, it's just frustration more than anything. (P18 line 19)

It is unclear how much he is talking about his frustration of deconditioning in hospital:

...what's caused your confidence to go?

Nothing's affected it. These things seem to spring up on you. You're lying in bed for a week and you lose your strength. See, That's the trouble. (P18 starts line 9)

However, reviewing my post-interview reflective notes, I record some surprise in how difficult it was to get any feeling of a lived-experience. I note, the referring staff highlighted the participant for the study due to the fact he was significantly struggling with his confidence mobilising (and obviously has used the word to trigger the referral). They recount that they had delayed his new package of care starting because his mobility confidence was so poor, and this was

affecting achievement of his goals. He mentions his package of care, but not in this context:

...on the road to recovery?

Yer, but you got to cover your end, by arranging a package to help me, which is a bit scarce, I think. That's what I'm waiting for. (P18 starts line 32)

It is hard to understand why the two parties' positions are in conflict? At the end of my reflective notes I comment:

'His strength of character and that of his father ([another] proud fisherman) showed some bravado ... , maybe a reflection too on why men are not using the confidence word so much...' (P18 - Post interview reflective notes, 5th March 2018).

This interview, like some others, following the turning off of the digital recorder the participant continues to talk about the topic of confidence. During the recorded interview it felt so hard to keep a connection to confidence during the conversation, afterwards he candidly speaks of it: *You've got to build up your confidence (handwritten notes post-interview)*, From the notes scribbled down as he continued to talk, I recalled him speaking about how a co-dependency existed between himself and his wife at home. He was worried about how long he has been in hospital and how she is managing. He recalls how co-dependent they are on each other and how confidence exists within this mutual support for each other – physically and emotionally. He has poor eye sight (I read the participant information sheet to him and printed off a large font copy for him to eventually take home), and she has recently been out of hospital, following eight weeks in after a fall in which she fractured her clavicle. She suffers with mobility problems too.

This boldness of character that was clearly there during the recorded interview, was clearly not all of the picture. Re-reading the transcript again and again, to try and see deeper to what was actually being said, I feel I start to understand something more. Through the presence of masculinity, a subtle vulnerability appears. And in this vulnerability a lack of confidence. *'You've got to build it up again...' (Line 6)* is a clear response to the question asking about his experience of confidence. His physical strength loss and its impact on practical function is his clear frustration. This connected to deconditioning following his acute treatment for a gastrointestinal haemorrhage, that left him bedbound. He then contradicts himself, he denies confidence loss (Line 19), connecting the emotions he feels to physical weakness, describing it *creeping up* upon him (Line 21), seeming while lying in bed. *Determination* and *hope* (Lines 26 and 28) are presented as solutions.

A vulnerability appears when he starts to talk about loss, into his eighties. Still mackerel fishing to that point, he has a few falls in the harbour itself and this triggers him giving up his boat. Denying being rattled by this more unusual type of fall, he goes on to talk about *packing up* (Lines 40 and 45) his livelihood, he seemed to say goodbye to that *Part of the experience of fishing* (Line 47) he lived for. Sale of his boat, one he rebuilt after his father's death, He talks of socially remaining connected, via the Fisherman's Mission, before he loses that too, when it closes down in the town. For me, although confidence is not mentioned, confidence is present throughout his narrative. Knowing from the healthcare staff his struggle with mobility and how his confidence is holding him back so significantly, it can only but be present in this conversation. Elements of lived-loss and confidence connections become a theme emerging from a wider contextual review of this study participant and appear as a theme above, maybe more clearly understood in the context explained here.

Becoming deeply connected to the individual and reaching a little deeper to understand better is driven by knowing a little about a context of a lived-experience. This supports a more accurate interpretation.

Appendix 4: Health Research Authority Ethics Approval Letter


Health Research Authority

Mr Frazer Underwood
Consultant Nurse, Older People / Associate Director of Nursing
Royal Cornwall Hospitals NHS Trust
Royal Cornwall Hospital
Bedruthan House
Truro
TR1 3LJ

Email: hra.approval@nhs.net

09 November 2016

Dear Mr Underwood

Letter of HRA Approval

Study title: Understanding the phenomena of 'confidence' in frail older people and implications for practice

IRAS project ID: 182665

REC reference: 16/YH/0363

Sponsor: Royal Cornwall Hospitals NHST

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read *Appendix B* carefully, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Page 1 of 8

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval/.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk/hra-approval/), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](http://www.hra.nhs.uk/hra-approval/).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>.

Your IRAS project ID is 182665. Please quote this on all correspondence.

Yours sincerely

Michael Pate
Assessor

Email: hra.approval@nhs.net

Copy to: Dr Clark Crawford, Royal Cornwall Hospitals NHS Trust – Sponsor's contact and lead NHS R&D contact.

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Interview schedules or topic guides for participants [Appendix 1p - Interview Guide]	0.1	07 July 2016
IRAS Application Form [IRAS_Form_03082016]		03 August 2016
Letter from sponsor [Letter re RCHT sponsorship of study]	2.0	23 July 2013
Other [Statement of Activities]	1	08 November 2016
Other [Schedule of Events]	1	08 November 2016
Participant consent form [RCHT - Patient Cohort Consent]	0.4	07 November 2016
Participant consent form [RCHT Carer Cohort Consent]	0.4	07 November 2016
Participant consent form [RCHT Healthcare Staff Consent]	0.4	07 November 2016
Participant consent form [CFT Patient Cohort Consent]	0.4	07 November 2016
Participant consent form [CFT Carer Cohort Consent]	0.4	07 November 2016
Participant consent form [CFT Healthcare Staff Cohort Consent]	0.4	07 November 2016
Participant information sheet (PIS) [RCHT Patient Cohort Information Sheet]	0.4	07 November 2016
Participant information sheet (PIS) [RCHT Carers Cohort Information Sheet]	0.4	07 November 2016
Participant information sheet (PIS) [RCHT - Healthcare Staff Cohort Information Sheet]	0.4	07 November 2016
Participant information sheet (PIS) [CFT Patient Cohort Information Sheet]	0.4	07 November 2016
Participant information sheet (PIS) [CFT Carers Cohort Information Sheet]	0.4	07 November 2016
Participant information sheet (PIS) [CFT Healthcare Staff Cohort Information Sheet]	0.4	07 November 2016
Research protocol or project proposal [IRAS 182665 Qualitative Protocol v0.2]	0.2	18 July 2016
Summary CV for Chief Investigator (CI) [Appendix 1a - CV Chief Investigator]	0.1	01 August 2016
Summary CV for supervisor (student research) [Appendix 1b - CV Director of Studies]	0.1	01 August 2016
Summary CV for supervisor (student research) [Appendix 1c - CV Second PhD Supervisor]	0.1	01 August 2016

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the [participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented \(4.1 of HRA assessment criteria\)](#) sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Dr Clark Crawford
Tel: 01872 256424
Email: rcht.sponsor@nhs.net

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	Following REC favourable opinion, the information sheets and consent forms were updated to bring them in line with HRA standards.
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	A Statement of Activities will form the agreement between the Sponsor and participating sites.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No funding is being offered to participating sites. Sites should note that, although the Schedule of Events accurately describes the study, no cost attributions have been made.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

All participating organisations are conducting the same activities, in line with the protocol, therefore there is one site type.

For older people living with frailty and their carers, recruitment will be through the care teams. The Chief Investigator will provide study information and recruitment strategies to senior ward or intermediate care service doctors, nurses and allied health professionals. The care service doctors, nurses and allied health professionals will talk to suitable patients about the study and give them a Participant Information Sheet (PIS). The Chief investigator will obtain consent and undertake all future study related activities.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Sites will be expected to formally confirm their capacity and capability to host this research.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented* (4.1 of HRA assessment criteria) section of this appendix.
- The [Assessing, Arranging, and Confirming](#) document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

The Chief Investigator will be the local Principal Investigator at the Royal Cornwall Hospital.

A local collaborator at the Cornwall Foundation Trust has been identified.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

Where arrangements are not already in place, external staff undertaking any of the research activities listed in A18 or A19 of the IRAS form would be expected to obtain a Letter of Access, based on standard DBS checks and occupational health clearance.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

- The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 5: University of Plymouth Ethics Approval Letter



Friday 2nd December 2016

CONFIDENTIAL

Mr Frazer Underwood
Consultant Nurse, Older People / Associate Director of Nursing
Royal Cornwall Hospitals NHS Trust
Royal Cornwall Hospital
Bedruthan House
Truro
TR1 3LJ

Dear Frazer,

Application for Approval by Faculty Research Ethics Committee

Reference Number: (16/17)-640

Application Title: Understanding the phenomena of 'confidence' in frail older people and implications for practice

I am pleased to inform you that the Committee has granted approval to you to conduct this research.

Please note that this approval is for three years, after which you will be required to seek extension of existing approval.

Please note that should any MAJOR changes to your research design occur which effect the ethics of procedures involved you must inform the Committee. Please contact Sarah Jones (email sarah.c.jones@plymouth.ac.uk).

Yours sincerely

Professor Michael Sheppard, PhD, FAcSS
Chair, Research Ethics Committee -
Faculty of Health & Human Sciences and
Peninsula Schools of Medicine & Dentistry

Faculty of Health & Human Sciences
Plymouth University
Drake Circus
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T +44 (0)1752 585339
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E sarah.c.jones@plymouth.ac.uk
W www.plymouth.ac.uk

Professor Michael Sheppard
CQSW BSc MA PhD FAcSS
Chair, Faculty Research Ethics
Committee

Appendix 6: Final correspondence approving the non-substantial protocol amendments

From: <hra.amendments@nhs.net>
Date: 22 August 2017 at 12:18:27 BST
To: <frazer.underwood1@nhs.net>, <rcht.sponsor@nhs.net>
Cc:
Subject: IRAS 182665. Amendment categorisation and implementation information

Amendment Categorisation and Implementation Information

Dear Mr Underwood,

Thank you for submitting an amendment to your project.

If you have participating NHS/HSC organisations in any other UK nations we will forward the information to the relevant national coordinating function(s).

Please note that you may only implement changes described in the amendment notice.

What Happens Next?

Information Specific to Participating NHS Organisations in England

1. You should now share details of the amendment and, if applicable, amended documents, together with this email, with all participating NHS organisations in England. In doing so, you should include the [NHS R&D Office](#), [LCRN](#) (where applicable) as well as the local research team. A template email to notify participating NHS organisations in England is provided on the [HRA website](#).
2. The participating NHS organisations in England should prepare to implement this amendment.
3. Your amendment has been assessed against [HRA standards](#). **This email also constitutes HRA Approval for the amendment, and you should not expect anything further from the HRA.**
4. You may implement your amendment at all participating NHS organisations in England 35 calendar days from the day on which you provide the organisations with this email and your amended documents (or as soon as the participating NHS organisation confirm that you may implement, if sooner). **NHS organisations do not have to confirm they are happy with the amendment.**
5. You may not implement the amendment at any participating NHS organisations in England that requests additional time to assess, until it confirms that it has concluded its assessment.
6. You may not implement at any participating NHS organisation in England that declines to implement the amendment.

IRAS Project ID:	182665
Short Study Title:	Understanding the phenomena of 'confidence' in frail older people
Date complete amendment submission received:	10/08/2017

Amendment No./ Sponsor Ref:	NS01
Amendment Date:	10 August 2017
Amendment Type:	Non-substantial
Outcome of HRA Assessment	This email also constitutes HRA Approval for the amendment , and you should not expect anything further from the HRA.
Implementation date in NHS organisations in England	35 days from date amendment information together with this email, is supplied to participating organisations
For NHS/HSC R&D Office information	
Amendment Category	A

If you have any questions relating to the wider HRA approval process, please direct these to hra.approval@nhs.net.

If you have any questions relating to this amendment in one of the devolved administrations, please direct these to the relevant [national coordinating function](#).

Additional information on the management of amendments can be found in the [IRAS guidance](#).

Please do not hesitate to contact me if you require further information.

Kind Regards

Ali Hussain

Amendments Coordinator

Health Research Authority

HRA, Ground Floor, Skipton House, 80 London Road, London, SE1 6LH

E: hra.amendments@nhs.net

6th November 2017

CONFIDENTIAL

Mr Frazer Underwood
Consultant Nurse, Older People / Associate Director of Nursing
Royal Cornwall Hospitals NHS Trust
Royal Cornwall Hospital
Bedruthan House
Truro
TR1 3LJ

Dear Frazer

Amendment to Approved Application

Amendment Reference Number: 16/17-811
Original application Reference Number: 16/17-640
IRAS Reference Number: 182665
Application Title: Understanding the phenomena of 'confidence' in frail
older people and implications for practice

I am pleased to inform you that the Committee has granted approval to you
for your amendment to the application approved on 2nd December 2016.

Please note that should any MAJOR changes to your research design occur
which effect the ethics of procedures involved you must inform the
Committee. Please contact Sarah Jones (email hssethics@plymouth.ac.uk).

Yours sincerely,

Professor Paul H Artes, PhD MCOptom
Professor of Eye and Vision Sciences
Co-Chair, Research Ethics Committee -
Faculty of Health & Human Sciences and
Peninsula Schools of Medicine & Dentistry

Appendix 7: COREQ Checklist (Consolidated criteria for REporting Qualitative studies)

No. Item	Guide questions/description	Reported on Page
Domain 1: Research team and reflexivity		
<i>Personal Characteristics</i>		
1. Inter viewer/facilitator	Which author/s conducted the interview or focus group?	133
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	26-28
3. Occupation	What was their occupation at the time of the study?	26
4. Gender	Was the researcher male or female?	1
5. Experience and training	What experience or training did the researcher have?	26-28, 137
<i>Relationship with participants</i>		
6. Relationship established	Was a relationship established prior to study commencement?	130-132
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	130
8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	26-28
Domain 2: study design		
<i>Theoretical framework</i>		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	32-37
<i>Participant selection</i>		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	129-131
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	129-131
12. Sample size	How many participants were in the study?	142
13. Non-participation	How many people refused to participate or dropped out? Reasons?	143-146
<i>Setting</i>		
14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	142-146
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	143-146
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	142-146
<i>Data collection</i>		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	132-133

18. Repeat interviews	Were repeat interviews carried out? If yes, how many?	N/A
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	122, 134
20. Field notes	Were field notes made during and/or after the interview or focus group?	122, 125, 145-146, 155-157
21. Duration	What was the duration of the interviews or focus group?	144
22. Data saturation	Was data saturation discussed?	129, 145-146
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	N/A
Domain 3: analysis and findings		
<i>Data analysis</i>		
24. Number of data coders	How many data coders coded the data?	N/A
25. Description of the coding tree	Did authors provide a description of the coding tree?	N/A
26. Derivation of themes	Were themes identified in advance or derived from the data?	146-207
27. Software	What software, if applicable, was used to manage the data?	N/A
28. Participant checking	Did participants provide feedback on the findings?	214-215
<i>Reporting</i>		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	146-207
30. Data and findings consistent	Was there consistency between the data presented and the findings?	146-207
31. Clarity of major themes	Were major themes clearly presented in the findings?	146-207
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	14-207

Reference: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Social connections

The interpersonal impact on confidence through social connections with others: a social paradigm

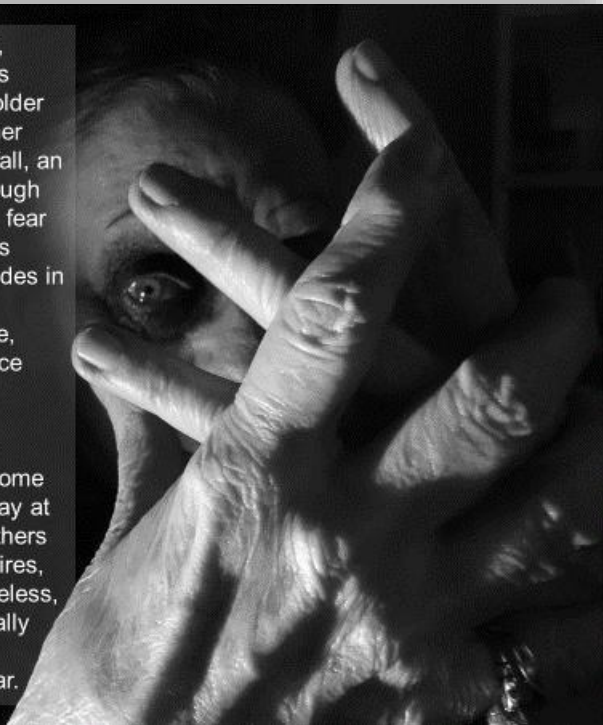
The social connection of others to an older person's confidence is as unique as the individual themselves. This interpersonal connection is relational, it is a social association between them, the significant other in their life and then directly to their confidence. This dimension takes countless forms and characters. It appears as a social bond that forms and shapes their confidence. These social bonds, or connections can be with family; partners, husbands or wives, with daughters and sons, or with siblings and their children. They maybe with: friends; with neighbours or carers; with health professionals in hospital or in the community; or with a religious faith and spiritual being. In turn, these social bonds, these personal, social connections to confidence can be strong or very fragile. In strength the connection with family, friendship and companionship gives confidence, hope and optimism. If this bond to others is broken, either permanently or temporarily; through loss of a spouse or abandonment of friends, or to the fleeting trust held in the carers supporting them, this broken connection leaves a person holding on to a frail confidence; a vulnerable confidence.



Fear

The relationship of fear to confidence exposes a powerful and emotive effect: a psychological paradigm

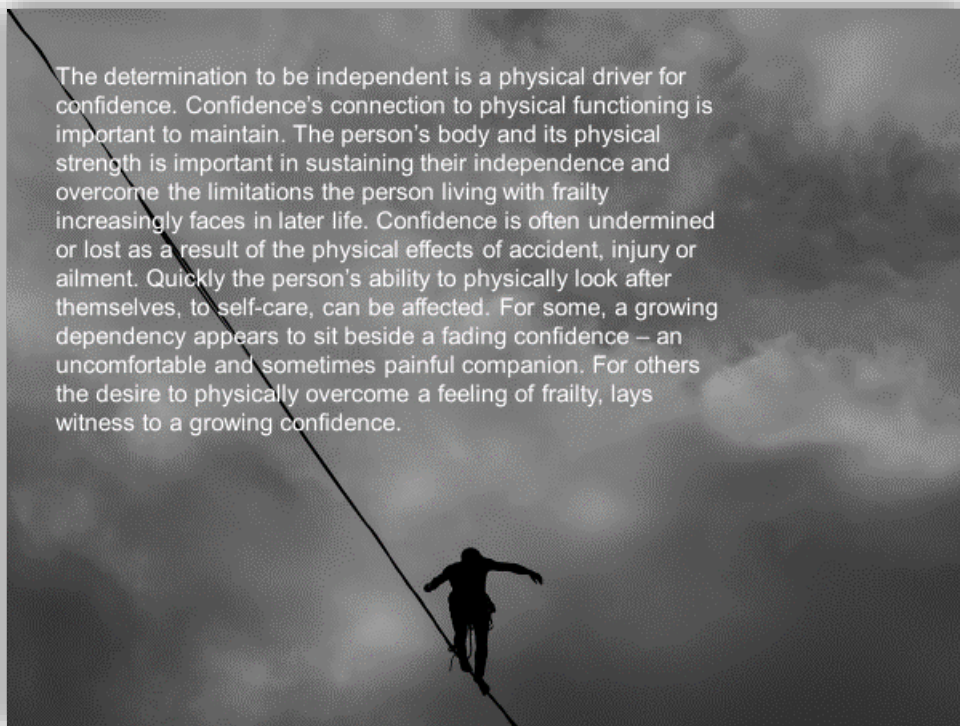
Fear (also referred to as dread, anxiety, fright, panic or worry) is tethered to the confidence for older people living with frailty. Whether triggered by an incapacitating fall, an illness such as delirium or, through the treatment or care received, fear can powerfully erode a person's inner confidence. This fear resides in the person's mind, playing psychological games. For some, they can speak to the confidence inside and try to bargain and rationalise with it, in some convincing way. These internal conversations attempt to overcome fear's ability to wear or tear away at the person's confidence. For others it completely disables their desires, leaving them helpless and hopeless, and for some completely mentally debilitated and depressed. Confidence is consumed by fear.



Independence

Physical independence is a stimulus to confidence: a physical paradigm

The determination to be independent is a physical driver for confidence. Confidence's connection to physical functioning is important to maintain. The person's body and its physical strength is important in sustaining their independence and overcome the limitations the person living with frailty increasingly faces in later life. Confidence is often undermined or lost as a result of the physical effects of accident, injury or ailment. Quickly the person's ability to physically look after themselves, to self-care, can be affected. For some, a growing dependency appears to sit beside a fading confidence – an uncomfortable and sometimes painful companion. For others the desire to physically overcome a feeling of frailty, lays witness to a growing confidence.



Control

The control of confidence is fundamental but not always achievable. Control exists at the crux of vulnerability and resilience: the control paradigm.

The control an individual has over their confidence is variable. Some older people living with frailty have a natural belief in the control they have over their confidence. These people often refer to their experience of confidence over their life-course, a confidence that has been shaped, by themselves, but often by others. This confidence carries forward into older age. However, as frailty becomes recognisable in their bodies and minds, the vulnerability of control over their confidence may falter and they become hesitant. This vulnerability is influenced by a reliance on other social, psychological and physical factors. For example, social connections (family, friends, healthcare professionals, neighbours or carers) in older peoples' lives can be control givers or control removers.





A strong connection to a social group, to family and friends, can liberate a person's control over a vulnerable confidence. The opposite sees loneliness and isolation limiting control and removing their resilience and then their confidence. Mental or psychological control over matters of confidence help some people, but mental fragility removes this control quickly and can rapidly take confidence away from their grasp. Regarding physical factors and independence, strength building and activities like goal-planning and target setting to regain mobility and self-care capabilities help gives control back. For others their control over confidence in physical matters will always be a struggle, overwhelmingly influenced by complex health problems, impairments and disabilities. There is a constant tension between the person's internal control over their confidence and external control or controlling factors that affect their inner confidence.

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